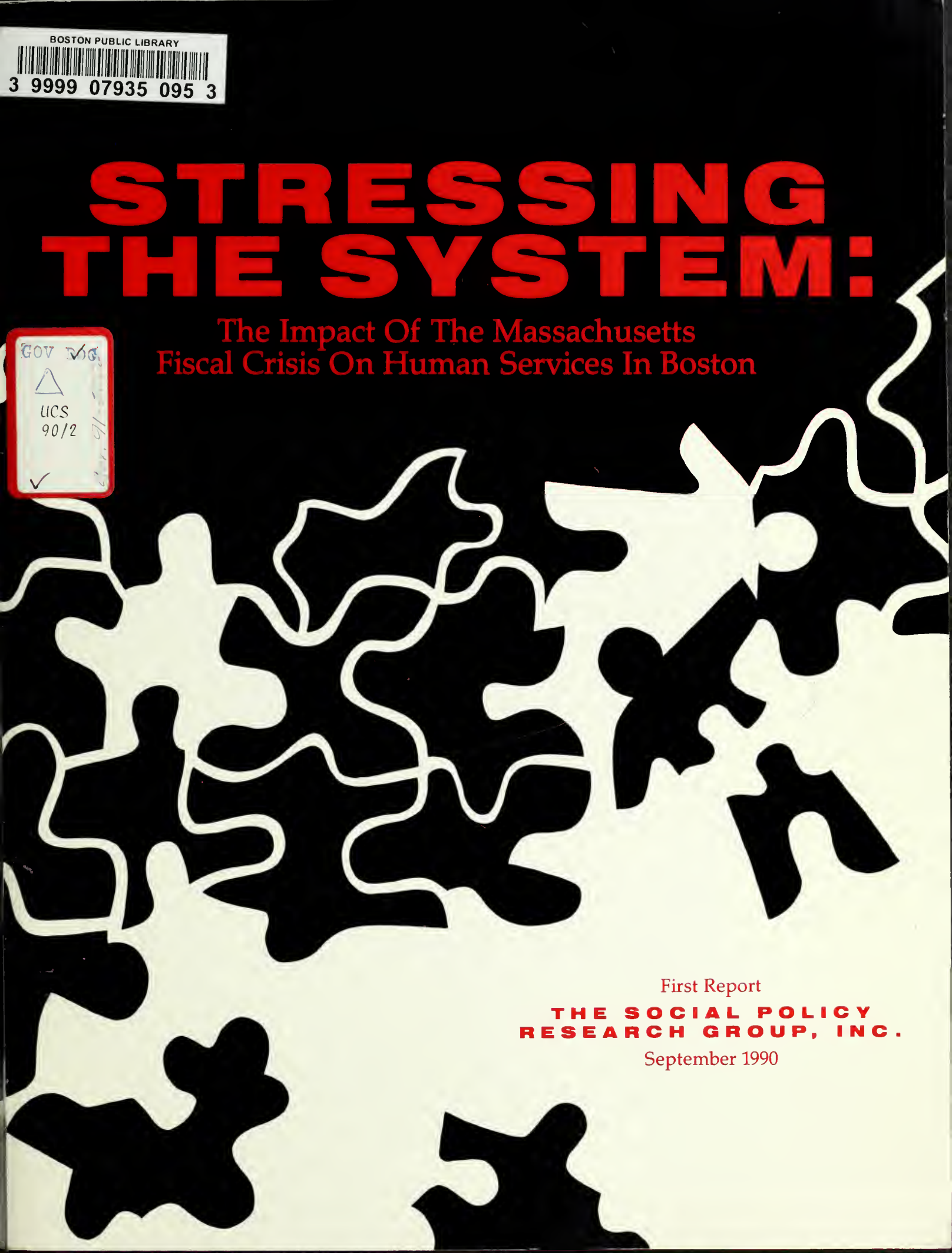
STRESSING THE SYSTEM:

The Impact Of The Massachusetts Fiscal Crisis On Human Services In Boston



First Report

THE SOCIAL POLICY RESEARCH GROUP, INC.

September 1990

The President's Message

In response to mounting columns of newsprint and increasingly strident editorials in Boston's media about the state's growing 1990 budget deficit, the Social Policy Research Group, in September of 1989, began a series of discussions with city and state officials, Boston area funders, and human service providers. Our purpose was to inquire about information they might need to aid them in planning for and managing the decline in state-supported human services.

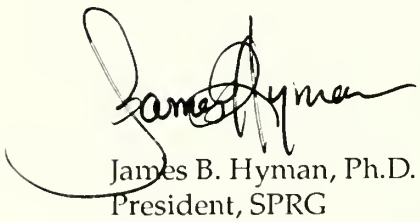
Boston area funders, already besieged by larger and more numerous requests from a widening variety of programs, complained of lacking a framework within which to determine how programs and services sponsored by the state combined to meet community needs, or how the impacts of funding changes in individual programs and services could be compared with those of other services competing for private sector support.

Government administrators also expressed a need to understand more about how decisions within their compartmental areas were actually changing the shape of the system of care. And providers with whom we talked have long been frustrated that the efforts they exert on behalf of people in need are neither well understood nor, in their view, appreciated by the general public. For these reasons the project we report on in this publication was undertaken as a major focus of SPRG's 1990 and 1991 research agendas.

It is our hope that the observations we report here will be useful to policy makers and observers both within and beyond the borders of the state of Massachusetts. Data from the National Association of State Budget Officers indicates that 35 of the nation's 50 states faced operating deficits in 1990.

Finally, we are deeply grateful for the early support and endorsements we received for this project from:

Associated Grant Makers of Massachusetts
Massachusetts Council of Human Service Providers
Mental Health Corporations of Massachusetts
United Way of Massachusetts Bay



James B. Hyman, Ph.D.
President, SPRG

The Board of Directors and the staff of the The Social Policy Research Group wish to extend special thanks to Ingalls, Quinn & Johnson, for contributing the art work on the cover and interior of this publication.

STRESSING THE SYSTEM:

The Impact Of The Massachusetts Fiscal Crisis
On Human Services In Boston

FIRST PROJECT REPORT

September 1990

THE SOCIAL POLICY RESEARCH GROUP, INC.

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About The Social Policy Research Group

The Social Policy Research Group is an independent, nonprofit community-based research organization with roots in Boston dating back 75 years. Reincorporated in 1986, its mission is to provide research, evaluation and demonstrations in areas of social policy of priority concern in the Greater Boston area. The Social Policy Research Group is not affiliated with any political group or governmental body.

Executive Summary

Fiscal year 1990 marked the third consecutive year of revenue shortfalls in the Massachusetts state budget. However, it was the first year in which there were no revenues in reserve to partially close the gap. The volume of the state's budget debate increased and became more acrimonious as deficit estimates grew from less than $500 million in the summer of 1989 to the $1.4 billion level officially recognized today.

In September, 1989, the Social Policy Research Group began a two-year effort to document the impact of the state fiscal crisis on human services in Boston. The study was launched in response to mounting concern and increasing uncertainty about the effect of the state's growing fiscal crisis on the Commonwealth's human services system and the people it serves. Two goals were established for the project: (1) to provide a thorough description of the human services delivery system; and (2) to document how the state fiscal crisis affects human services.

This report is the first in a series presenting the findings of the project. It focuses on Boston's network of private provider agencies. Its conclusions are based upon extensive telephone interviews with executives of 198 of these agencies, discussions with human service advocates, and conversations with city and state officials. These efforts represent only the first data collection steps in the study, so the findings presented here must be considered preliminary. The telephone survey has already been followed by more detailed in-person interviews with executives from a sample of 55 agencies. In order to provide greater depth and longitudinal perspective, these in-depth interviews will be repeated twice more during the course of fiscal 1991. As a final step, these analyses will be supported by a review of agency financial reports and a more limited survey of private providers state-wide. The combination of these data will provide an objective and comprehensive framework for evaluating the impact of the fiscal crisis on human services in Boston.

Five Questions

Five questions listed below are central to this study. They will be used to guide the present report as well as the overall two-year study effort.

- Funding Changes: How has the fiscal crisis affected funding for human services?
- Agency and Program Adjustments: What changes in agency operations and service delivery have occurred as a result of the funding changes?
- The Impact on Clients: How have clients been affected by funding reductions and what is the effect on the community as a whole?
- The Impact on the Integrity of the System: How do the impacts of funding reductions in individual agencies affect the entire system of care?
- State-wide Policy Implications: Is the Boston experience reflective of the state as a whole and can it be used as a guidepost for policy?

FUNDING

- In the state budget, privately-provided, or community-based, human services were level funded in fiscal year 1990. State spending for all privately-provided services rose by only 1%. Within this context, many services experienced funding cuts, while a few continued to command additional resources.

- Private providers in Boston reported that they received, in total, about the same amount of state funding in 1990 as in 1989. Translated into real (inflation-adjusted) dollars, however, 71% saw reductions. Agencies obtained support from many sources other than state contracts, but even when those were included, more than half of all agencies still had fewer real resources in 1990.

- Changes in the amount of state funds received by private agencies showed no bias either with regard to the racial composition of agency caseloads or the geographic areas served.

AGENCY AND PROGRAM ADJUSTMENTS

- Seventy-one percent of all agencies reported making reductions in one or more areas of their own budgets and 30% had smaller workforces.

- Agencies reported that a variety of budget-stretching changes in service delivery took place in fiscal 1990, including increased staff workloads, longer working hours, less frequent client contact, and shorter overall treatment periods. Further research is needed to explain these shifts, which were not found to be directly related to funding reductions.

THE IMPACT ON CLIENTS AND CASELOADS

- Agencies served about the same number of clients in fiscal 1990 as in fiscal 1989 but the needs of the community increased and waiting lists rose.

- Agencies reported that their caseloads shifted in 1990 toward clients who were more difficult to serve. The causes of this shift were not observed directly but likely include increased community needs, policy changes that limit access for clients with less severe needs, and/or decisions by agencies to concentrate resources on the hardest to serve.

THE INTEGRITY OF THE SYSTEM

- The network of providers behaves more like a loose confederation than a true, integrated system. Still, various important connections do exist and providers and observers of the human services system in Boston report that these connections have been strained by the budget crisis in fiscal 1990.

Conclusion

In fiscal year 1990, Boston's private human service providers served a smaller portion of those in need. Most agencies cut some areas of their budget but were able to serve about as many clients as the year before, despite level funding from the state. Clients were more difficult to serve, however, and the needs of the community continued to rise. As a result, access to care became more limited and waiting lists for service grew throughout the system.

While it is clear from our analyses that the human service system in Boston was not dismantled, as many advocates feared, our observations clearly show it to be a system under stress. Private providers of human services in Boston learned to do more with less in 1990 while community needs increasingly went unmet and demand for services continued to exceed service capacity. Major questions, yet unanswered, involve the impacts of the crisis on the quality of services delivered, the fate of preventive and early intervention services, and the effects that cuts in discretionary programs may have on entitlement spending. Future research will also focus on assessing the impacts of the crisis on communities of clients, on the connections that exist among service providers, and, finally, on the capacity of the system to provide effective service.

Advisory Structure

Because of the highly political and often emotional nature of public resources allocations, The Social Policy Research Group employed an advisory structure to guide and direct its explorations. A Steering Committee and a Technical Advisory Committee were formed. Nineteen participants were recruited from throughout the greater Boston area as a result of an extensive nominations process involving consultations with dozens of Boston community, political and business leaders. SPRG owes a great debt of gratitude to these advisors for the contributions they have make to this work and for their continuing commitments to this project. The charges and membership of our two committees are provided below:

STEERING COMMITTEE

The role of the Steering Committee is to ensure the utility of this work. In this role it provided advice and counsel on every aspect of the projects direction including: its scope, major questions to be addressed, and its dissemination strategies. Its membership is listed below:

Joseph Doolin
Archdiocesan Director
Catholic Charities

Richard Jones
Executive Director
Boston Children's Service Association

Frank Keefe
Senior Vice President
JMB/Urban Development

Judith Kidd
Donor Relations Manager
The Boston Foundation

Richard Manley
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Barry Schrage
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Combined Jewish Philanthropies

Beth Smith
Executive Director
The Hyams Foundation

Stephen K. Wagner
Partner In Charge — Audit
Deloitte & Touche

Bill Weber
President
Boston Panel of Agency Executives

Deborah Weinstein
Executive Director
Massachusetts Human Services Coalition

TECHNICAL ADVISORY COMMITTEE

The Technical Advisory Committee for the for the project is comprised of respected researchers and academics from various institutions within the Boston community. Its charge was reviewing the technical aspects of this project including commenting on SPRG's research design and survey instruments as well as critiquing the findings presented in this paper. The following is a list of its membership:

Kathy Bradbury
Assistant Vice President and Economist
Federal Reserve Bank of Boston

Ron Ferguson
Associate Professor, Public Policy
John F. Kennedy School of Government
Harvard University

Paul Harrington
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Center for Labor Market Studies
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The Social Policy Research Group would like to acknowledge the voluntary contributions, support and cooperation of Boston's business and community leaders, human service advocates and providers, and city and state government officials. Without their continued support, this ambitious project could never have been launched. The Social Policy Research Group is, however, solely responsible for the results of this research. Conclusions or opinions presented here should not be taken to represent the personal views of any person named here.

SPRG would like to acknowledge

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Finally, we express sincerest thanks to the 230 agency executives who participated in our survey. Without their participation and cooperation this effort would not have been possible.

Contents

INTRODUCTION

I Introduction

Fiscal year 1990 was, by most accounts, the third year of budgetary emergency for the Commonwealth. Fiscal 1988, the first year of the crisis, passed with little notice and the mismatch between revenues and spending ($522 M of the approved $11.5 B budget) was patched with a surplus carried forward from previous years. In 1989, the gap widened to consume the Commonwealth's small stabilization, or rainy day, fund and leave a year-end deficit of $442 million (at the $12.3 B budget level). For these two years, the crisis seemed almost surrealistically non-economic: employment and incomes continued to rise, unemployment stayed well below the national average, and both business and government leaders were bullish. Rather, the problems seemed to be due to a series of one-time revenue shortfalls, some associated with the Federal Tax Reform Act of 1986, and to runaway spending in a small number of programs labeled "budget busters" by the Senate Ways and Means chair. By 1990, employment fell and the unemployment rate rose rapidly, and the state's budgetary imbalance worsened drastically. The deficit for fiscal year 1990 was $1.4 billion.

Whether 1990 was the last year of fiscal crisis in Massachusetts is debatable. In his veto message, Governor Michael Dukakis wrote, "The Fiscal Year 1991 budget I am signing today will restore our fiscal stability and set the stage for economic recovery."[1] Many observers disagree. If they are right, more cuts will be needed in fiscal 1992, and the long-running fiscal crisis will continue through yet another year's budget debate.

If the crisis does become (more) protracted, decision making at every level will likely become increasingly difficult, and may lead finally to absolute choices among state-supported programs and a permanent alteration to the menu of services available. So far, state cutbacks have preserved program structure, aiming instead at a broad scaling-back of state government. As a result, most public and private agencies muddled through fiscal year 1990, making adjustments in management, staffing or program operation, but avoiding fundamental changes. As one observer put it: "They have not accepted the permanency of the crisis." One goal of this study is to provide the basic information, now lacking, which will be needed to make these very difficult choices when they ultimately have to be made.

Goals of the Study

This study focuses on community-based human services supported by the state through purchase of service contracts with private provider agencies. It will not focus directly on either state expenditures for assistance programs (e.g., AFDC or General Relief) or services provided directly by the state (e.g., state institutions such as mental health hospitals).

In the past few years, as the Massachusetts fiscal crisis deepened, concerns grew that spending cuts would have a significant effect on human services. But the complexity of the state budget and of the human services delivery system has made it difficult to assess these impacts. Instead of focusing on how clients and programs have been affected, most discussion has centered on budgetary bottom lines or on anecdotal evidence

of either human need or bureaucratic waste. These narrow perspectives cannot be used as a guide for objective decision making; a more general framework is required. This, in turn, is hard to develop because basic knowledge of what human services are, how they are delivered, and who they help is lacking.

This study, begun in January 1990, represents a comprehensive two-year effort to respond to these needs by focusing on privately-provided services. Its goals are to develop: (1) a basic understanding of the human services delivery system; and (2) the framework necessary to judge the impacts of funding decisions. This report is the first in a series aimed at addressing these goals. Two additional reports are planned for release prior to the study's conclusion late in 1991.

GOAL #1: UNDERSTANDING HUMAN SERVICE DELIVERY

In a time when difficult choices must be made affecting thousands, very little is known about the array of services that state government buys. As a key Boston business leader said in calling for a catalog of those services: "What do we have? What do we need? What can we afford? These questions are not being fully answered."[2] Even officials in state government have conceded that not much is known about the system of care in Massachusetts. After more than two years of studying the system of private human service delivery, Peter Nessen, then Assistant Secretary for Administration and Finance, concluded that "We know nothing at all about the product, the outcome, and most important, the effect of the program for the client."[3]

As a first step in answering these concerns and as part of this research effort, SPRG has produced a guide to Boston's human services system mapping which services are being offered, how they are funded, and how clients move among agencies and programs. Titled *A Primer on Human Services in Boston*, this guide is a companion release to this report.

GOAL #2: ESTIMATING IMPACTS

Further complicating the difficult choices that lie ahead is the lack of a framework within which we can evaluate how budget and policy decisions on individual services will affect the state's overall human services safety net.

The human services system in Massachusetts, as in other states, involves an intricate network of public and private agencies and encompasses a vast array of programs and services, managed by many compartments of state government. Moreover, treatments, delivery mechanisms, costs, and intended outcomes differ markedly from one service to the next. Yet, taken together, this panoply of services constitutes a system of care that must somehow meet the multiple needs of the citizenry.

Understanding how it is affected by the state's fiscal crisis is the principle focus of the study. Consequently, throughout the study SPRG will identify the impacts of the state fiscal crisis both within individual areas of human services as well as across this system of care taken as a whole.

Five questions, reported below, are central to these investigations. Together they form the themes that guide this report and the remainder of the study. These questions are intended only to document the effects of the fiscal crisis — not to be prescriptive, evaluative or predictive. They are intended to provide broad-based empirical estimates that will reduce our reliance on anecdote and presumption as principle tools guiding policy decisions in this difficult fiscal environment. The questions are:

1. **Funding Changes:** *How has the fiscal crisis affected funding for human service agencies?* Here we will focus on the agencies that deliver human services within the City of Boston, and on how changes in appropriations for those services are affecting them. Over the life of this study, research will examine whether the crisis has fulfilled the worst fears of human services advocates that the state's system of care would be dismantled.

2. **Agency and Service Adjustments:** *What changes in agency operations and service delivery have occurred as a result of the funding changes?* In these investigations, the study probes the mechanisms human service agencies employed to cope with changes in funding induced by this crisis. Of particular interest to the study over time will be examination of the implicit objectives underlying agency behaviors in coping with funding changes. Do agencies make decisions that save agency jobs as opposed to services, for example?

3. **The Impact on Clients:** *How have agency clients and caseloads been affected, and what is the effect on the community as a whole?* Ultimately, changes in funding levels will affect the clients who are receiving services. This focus in the research will identify changes in the caseload and client access to services which may result from funding cuts. While issues related to the quality of service are not our focus and hence will not be directly observed, reasoned hypotheses for future investigation will be posed in our final project report late in 1991.

4. **The Integrity of the Human Services System:** *How do the impacts of funding reductions in individual agencies affect the entire system of care?* This research presumes that impacts in individual program areas should not be viewed in isolation. Clients often have multiple human services needs which must be addressed by a system of care. Some of these, such as housing and daycare, must be met before others can be effectively addressed. Because certain services act as a foundation on which other services must be built, they form what we consider a human services infrastructure. While in this report we will do little more than introduce this concept, a long-term objective of the research will be to determine the extent to which this human services infrastructure has been affected by the crisis.

5. **State-wide Policy Implications:** *Is the Boston experience we observe in this study reflective of the state as a whole, and can it be used as a guidepost for state policy?* This question, not addressed in this report, will be investigated through data collection on a statewide survey and discussed in this project's final report in 1991.

As earlier stated, these questions will be the central themes pursued throughout this study. As such, our understanding of these issues will continue to evolve as further data collection and analyses progress. In this volume we will present our initial observations, in the hope that they are useful to policy makers and the public, and will improve our

understanding of the relationships between state level budget decision making and the services delivered to the citizens of Massachusetts.

Although this study is a response to a specific crisis, there is a long-term need for the analytic framework it promises. This is true, in part, because the Commonwealth's budget problems are themselves long-term. The crisis and its impacts must be seen as a process which will play itself out over a number of years, and not as a one-time phenomenon. This two-year study, while a beginning, will not fill the long-term analytic needs of the state's administrators, its legislators, or its public.

This Report

This report is the first in a series presenting the findings of the project. It is based upon extensive telephone interviews with executives of 198 (out of the 272) private provider agencies in Boston, discussions with human service advocates, and talks with city and state officials. During the course of the project, these initial data will be complemented by information from many other sources. The telephone survey has already been followed by more detailed in-person interviews with a sample of 55 agency executives. In order to provide greater depth and a longitudinal perspective, these interviews will be repeated twice more during the course of fiscal 1991. Finally, these analyses will be supported by a review of agency financial reports and a more limited survey of private providers state-wide.

Part One of the report, which follows, lays the foundation for this research by establishing the state budget context for human services and defining and describing the private human services system in Boston. This discussion is provided to give the reader the larger perspective in which to view the findings presented in Part Two. In Part Two, findings on the five major questions will be presented in turn. Part Three of the report will be used to present general conclusions across our analyses, raise questions yet unanswered at this stage of our investigations, and point the directions for our continuing efforts in this project.

PART ONE:
SETTING THE STAGE

II The Foundations for Study

A review of the larger state budget for human services is necessary before we can present Boston's human service system and discuss how it is affected by the state fiscal crisis. This review of state-level budget data and budgeting concepts forms the context for the study. Human services and Boston's network of private human service providers are then introduced and defined. Together, these discussions form the foundation for this report and for future study.

The Context: The State Budget for Human Services

The Commonwealth of Massachusetts spent $6 billion to provide human services to its citizens in fiscal year 1990.[1] Nearly one-half of all state dollars ($12.8 billion in 1990) are spent on human services, and this share is increasing. Human service programs can be divided into two categories: those providing cash and in-kind *assistance* to individuals[2] and those providing *direct services*, including care, counseling and treatment. In fiscal year 1990, spending growth in these two categories differed widely. Outlays for assistance programs rose by 16.3% while spending for direct service programs was nearly level, increasing by only 1.1%. The combined increase in spending for all state human service categories was 9.1%.

Table 1, which summarizes state human service spending from fiscal 1988 to 1990, further divides direct services between those provided directly by the state and those provided by private agencies under contract with the state. Institutional services, including correctional and DYS (Department of Youth Services) facilities, public health and mental health hospitals, Soldier's Homes, and state schools for the mentally retarded, is the largest category of state-provided services. Spending for these rose by 4.1% in fiscal year 1990 — down from the 14% increase allocated in 1989. In contrast, spending for other state direct services, including state social workers and administration, fell by 3.1% in 1990 after a 9.9% drop a year earlier. Together, these two categories of state-direct services accounted for 24% of the state human services budget in 1990 with a combined growth rate of 1.2%.

Privately-provided services include nearly all community-based care[3]. Spending for these, $1.2 billion, rose by 1% in 1990. While most of these programs are funded through the Executive Office of Human Services (EOHS), elder home care, adult education, and job training are funded through other secretariats. Table 1 also shows this division: Funding for privately-provided EOHS programs rose by 3.2% and that for non-EOHS services fell by 7.5%. A more detailed breakout of funding for privately-provided services is presented in Table 5.

Table 1

State Funding for Human Services

	Spending in Millions			Percent Change		Share of Human Services Budget
	FY88	FY89	FY90	FY89	FY90	FY90
Assistance Programs	2,472	2,894	3,366	17%	16.3 %	56%
Direct Service Programs	2,356	2,571	2,599	9.1	1.1	44
Privately-Provided	995	1,172	1,183	17.8	1.0	20
EOHS	778	930	959	19.5	3.2	16
Non-EOHS	217	242	224	11.6	(7.5)	4
State-Provided	1,361	1,399	1,416	2.8	1.2	24
Institutional Services	725	826	860	14.0	4.1	14
Other State Direct Services	636	573	556	(9.9)	(3.1)	9
Total Human Services Budget	4,828	5,465	5,965	13.2	9.1	100
Non-Human Service Items	6,633	6,870	6,822	3.6	(0.7)	-
TOTAL STATE BUDGET	11,461	12,335	12,787	7.6	3.7	-
Human Services as a share of the total state budget	42.1%	44.3%	46.6%	-	-	-

ENTITLEMENTS AND SPENDING DISCRETION

Many factors underlie the differences in rates of spending growth shown in Table 1. Most important among them is the degree of discretion budget makers and state administrators have to control spending, and that discretion varies with each category. Most of the programs in the assistance category are entitlement-based—meaning that the state is obliged to provide the assistance or service to any citizen defined by law as "entitled" to it. But even among non-entitlement programs, spending is more "controllable" in certain areas than in others. In all, about two-thirds of the state human services budget is non-discretionary. Spending on these programs expanded by 16% in fiscal 1990, driving the overall growth in the human services budget to the 9.1% level reported earlier. By comparison, spending on so-called discretionary programs actually fell by 2.8%. Budgetary pressures resulting from growth in entitlement-based programs have been a long-standing concern for both state and federal fiscal management.

By definition, current year spending in entitlement programs is controlled by legal obligation rather than by appropriations decisions. There are at least three classes of these obligations — those that are: (1) federally mandated; (2) established by state legislation; or (3) mandated by court order or other legal mechanism. In addition,

Table 2

Discretion in the State Human Services Budget

	Spending in Millions of Dollars			Percent Change	
	FY88	FY89	FY90	FY89	FY90
Non-Discretionary Spending	2,992	3,441	3,997	15.0%	16.1%
Discretionary Spending	1,837	2,024	1,968	10.2	(2.8)
Discretionary Share of Human Services Budget	38.0%	37.0%	33.0%	-	-

spending in certain categories of state activity can also be relatively uncontrollable, but for non-entitlement reasons.

The degree of obligation implied by each type of entitlement is different. Payments for federally guaranteed Medicaid services, for example, must be made regardless of the adequacy of appropriations to support them, and they cannot be abridged by any state legislative action. Entitlement benefits authorized by Massachusetts law are also not subject to appropriations limits, but the legislature can control costs by altering the legislative basis for the entitlement. Benefit levels and eligibility requirements for the state General Relief program are examples of items subject to legislative control that can contain costs, as are the state-mandated portions of the state/federal Medicaid and AFDC programs.

The third set of entitlements arise from court judgments and other legal obligations of the Commonwealth. Staffing and spending at state schools for the mentally retarded, for example, is protected by a 1973 court consent decree. This protection effectively removes the state schools from the budget cutting calculus at the Executive Office for Human Services. There is also an implicit entitlement embedded in the constitutional right-to-counsel. As with the federal programs above, the state cannot affect spending on these programs and services through appropriations or legislation.

Finally, there are non-entitlement programs and activities of the state which nevertheless limit legislative budget discretion. Correctional institutions, for example, must expand to accommodate convicted felons. And the state must provide protective services for children in need of them. These obligations, while very real, are not as strong as those described earlier. Occupancy often exceeds capacity in penal institutions and special parole and early release provisions can also be used to lessen the budget pressures.

The interaction between discretionary versus entitlement, controllable versus non-controllable spending is one of the more basic of budgetary dynamics. If entitlement spending grows at a rate that exceeds state budget growth, state managers and legislators, in order to meet these obligations, face great pressure either to increase the state budget or cut needed programs of a non-entitlement nature.

In 1990 for instance, these entitlement (non-discretionary) programs rose at a pace seven percentage points higher (16.3% compared to 9.1%) than the state budget as a whole. In the two years from 1988 to 1990, 88% of all spending increases in human services were in this non-discretionary, entitlement area. And indeed, our data suggest that this phenomenon exerted great pressure on state discretionary spending. During that same two-year period, discretionary spending fell as a proportion of overall state human services spending, from 38% to 33%. This implies that direct services, which comprise most of the state's discretionary spending, are subsidizing assistance programs in this state, whose draw on the state revenues goes on unconstrained.

This assertion is not intended to imply any judgement as to whether these transfers are either inappropriate or bad for the state of Massachusetts. They do not suggest, for instance, that funds should be re-allocated from entitlement to non-entitlement programs through some mechanism. Rather, they do imply very strongly that programs

and services which the state has elected to offer to its citizenry will continue to experience stress as the state's budget is constrained and as spending for entitlements continues to rise at high rates.

And though some observers of the state budget process may view reductions in discretionary programs as budget savings, further research is necessary to determine whether this is true in the long term. Future investigation should seek to determine whether constriction in discretionary programs, many of which are preventive, will itself induce significant additional claims and increased costs through entitlements such as welfare, for example.

The reality of the budget process is that spending cuts are possible only in areas where budget makers and managers have discretion to cut. And our investigations show that a further reality in Massachusetts in 1990 is that human services spending increases do not reflect conscious decisions to increase the human services budget. Rather, these increases came in areas largely outside the sphere of managerial and legislative control.

Defining Human Services

For the purposes of this study, SPRG needed to construct a framework to permit coherent observations across a very complex system of services and service deliverers. The following discussion presents our framework and rationale.

Human services encompasses a vast array of publicly supported person-helping activities. Human services systems include programs providing personal care, counseling, custody, treatment, training, education, and assistance with meeting basic human needs. In Massachusetts, they may be delivered by a state agency, by a city or town, or by one of the 1,200 private provider agencies across the state. The investigations in our study focus on human services provided by the state of Massachusetts through contracts with the private provider agencies. These private provider contracts are the vehicles by which the state funds local community-based services.

There is enormous diversity within these human services contracts. The Executive Office of Human Services (EOHS) recognized 244 distinct program types in its 1990 *Directory of Purchased Services*. Since this list does not include elder services, job training, adult education, or any other service outside the EOHS domain, the actual number of state-supported programs is even larger. This complexity makes each case virtually unique and generalizations impossible. Analysis requires that larger categories be created.

For the purposes of this study, an eight-sector taxonomy was developed. It is organized mainly along functional categories which relate to the services that are performed.

Table 3

A Taxonomy of Human Services: Summary

I.	**Counseling and Mental Health Services**	Mental Health Services Counseling Services
II.	**Health Care Services**	Substance Abuse Treatment Community Health Services
III.	**Education and Job Training Services**	Public Education Adult Education Job Training
IV.	**Services for Individuals with Special Needs**	Services for the Mentally Retarded Services for the Physically Disabled
V.	**Shelter-Based Services**	Homeless Shelter and Related Services Battered Women's Services Shelter for Runaways and Other Youth Pre-release Correctional programs
VI.	**Caregiving Services**	Day Care Services Substitute Family Care Elder Home Care and other Elder Services
VII.	**Public Assistance**	Income Maintenance and Transfer Programs Other In-Kind or Cash Assistance
VIII.	**Human Services Advocacy**	

Table 3 summarizes the SPRG taxonomy. A more detailed listing is included in the project's first technical report.

The SPRG Survey of Privately-Provided Human Services in Boston

With this framework in place, SPRG was able to begin data collection on the experiences of private agencies providing contracted human services in Boston. The initial data collection effort involved a telephone survey targeted toward all 272 of Boston's private providers.

The survey was conducted for SPRG by the Atlantic Marketing Research Company in February, 1990. Within the survey, which emphasized agency-level information, questions were asked in twelve specific service areas. These service areas represent component areas in the taxonomy, presented above. The exception is youth services, which is not listed as its own catergory. It has been constructed to include youth shelter and group homes, youth development programs, and adoption and foster care services. In

total, 198 interviews were completed, of the targeted 272. The distribution of responses by service area is summarized in Table 4.

Table 4

Boston's Private Human Service Providers

Service Area	Estimated Number of Providers in Boston	Number of Providers Interviewed
Mental Health	34	26
Mental Retardation	27	22
Physical Disabilities	19	15
Substance Abuse	46	36
Community Health	51	37
Elder Services	22	19
Day Care	61	48
Adult Education & Employment Training	44	35
Homeless Services	37	28
Services for Battered Women	7	6
Counseling	45	36
Other Youth Services	31	28
TOTAL	**272**	**198**

PART TWO:
FINDINGS

III Resources for Privately-Provided Human Services

How has the fiscal crisis affected funding for human services in Boston?

State-wide, the Commonwealth's funding for privately-provided human services rose by 1% in fiscal year 1990. Within this level-funded context, many services experienced funding cuts, while a few continued to command additional resources.

For Boston-based providers, this level funding meant that 71% received less real (inflation-adjusted) state contract support than they did in 1989. Agencies do have other sources of revenue, but even when these are included in the analysis, more than half of all agencies interviewed (56%) had fewer real resources in 1990.

The State Budget for Privately-Provided Services

In dollar terms, the Commonwealth spent approximately $1.2 billion on privately-provided community-based services in fiscal year 1990. This represents about one-tenth of the entire state budget, about one-fifth of the state's budget for human services, and almost half (46%) of all direct services spending. The state's reliance on private agencies to deliver services, virtually nonexistent in 1970, has grown steadily. Among EOHS departments, the share of total spending allocated to private agencies rose from 37% in 1988 to 41% in 1990.

Table 5 displays the state budget for privately-provided services in service areas which match the categories used in the SPRG survey. The table shows that very significant increases occur only in health. This is mostly due to an increase in one item, the Multiple Risk Factor Reduction Program, although funding for community-based AIDS programs ($5.3 million in 1990) continued to increase as well. Also increasing rapidly was contracted health spending for institutional populations, such as the mentally retarded, the mentally ill, and correctional inmates. Beyond these, funding for substance abuse treatment and pre-release programs for adult offenders also rose at rates which equaled or exceeded inflation. But all other service areas showed either declines or increases which did not keep pace with inflation. Dollar declines occurred in homeless services (down 8.8%), elder services (down 8.9%), adult education and job training (down 5.2%), daycare (down 0.3%), and family services and counseling (down 0.6%).

Table 5

The State Budget for Privately-Provided Human Services

	Spending in Millions			Percent Change	
	FY88	FY89	FY90	FY89	FY90
Mental Health	140	187	191	33.6 %	2.6%
Mental Retardation	168	222	231	32.0	4.1
Physical Disabilities	23	28	29	24.1	3.0
Substance Abuse	67	65	70	(2.3)	7.1
Community Health (see Note 1)	14	18	33	24.8	85.1
Elder Services	136	145	132	6.2	(8.9)
Daycare: Total	130	153	153	18.0	(0.3)
Contracted slots	82	93	94	13.6	1.1
Vouchers	41	53	51	29.5	(3.4)
Other	7	7	7	2.1	5
Adult Education & Employment Training	80	97	92	20.9	(5.5)
ET Choices	22	28	32	27.5	13.1
Other Programs	58	69	60	18.4	(13.1)
Homeless Shelter and Related Services	24	32	29	34.6	(8.8)
Family Services and Counseling (see Note 2)	159	155	154	(2.1)	(0.6)
DYS Programs	28	35	36	26.3	0.8
Other	26	34	33	28.5	(3.3)
TOTAL	**995**	**1,172**	**1,183**	**17.8**	**1.0**

Note 1: Large increase in Multiple Risk Factor Reduction Program accounts for much of the FY90 increase. Rise in AIDS funding also significant.

Note 2: Category includes battered women and youth shelters

Resources for Boston's Private Providers

Private providers in Boston reported that they received about the same amount of state funding in 1990 as they did in 1989. Translated into real (inflation-adjusted) dollars, however, 71% saw reductions. Agencies obtain support from many sources other than state contracts, but even when these are added, more than half of all agencies still had fewer real resources in 1990.

SOURCES OF SUPPORT

The 178 agencies reporting total revenues (20 of the 198 surveyed agencies had missing data) received $450 million in support from all sources. Given estimated response rates to the survey, this implies that the entire network of 272 providers in Boston had total revenues in 1990 of approximately $640 million. The average agency budget, given these figures, is nearly $2.4 million. Less than a quarter of Boston agencies are really this large, however. One-quarter have budgets less than $375 thousand and one-half less than $850 thousand.

State contracts constituted the largest portion of agency revenues in fiscal year 1990, representing 45% of combined agency budgets. Many agencies are heavily dependent upon state contract awards. Fifteen percent of them reported that more than 90% of their total revenues were attributable to state contracts and more than one in five agencies reported a greater than 80% dependence on state revenues. Agencies serving the mentally retarded and physically disabled were most dependent on state contracts. Least reliant were agencies offering health services and those serving battered women.

The dependency on state contracts was not found to vary with either the size or the age of agencies, even though it might have been supposed that older agencies would be less reliant on state contracts.[1]

One hundred seventy-seven (177) of our surveyed agencies reported recieving state contract awards totaling $192 million. Again extrapolating based on response rates, this implies contracts totaling about $274 million were awarded to Boston agencies in fiscal year 1990. By this estimate, nearly one-quarter of the state's $1.2 billion budget for community-based services is received by Boston-based agencies. This does not imply that Boston, with 10% of the state's population, necessarily receives a disproportionate share of state resources. Rather, it reflects the fact that the human services network is headquartered in Boston—more than half of all Boston-based agencies reported service areas which extended beyond city borders.

Private provider agencies in Boston derive support from a variety of sources in addition to state contracts. The most important of these are Medicaid and Medicare reimbursements, which comprised 15% of combined budgets and one-third of the budgets for community health agencies. Contracts and grants from the City of Boston and the federal government made up 10% of agency budgets. Thus, government funding accounted for 70% of the total support for the private agencies surveyed (45% contracts, 15% Medicaid/Medicare, 10% federal or city). Support from charitable sources, including the United Way, private foundations and corporations, and private giving, made up 11% of agency revenues. Other revenue sources, including interest earnings, fees, payments by insurance companies, and contributions from affiliated organizations (like a national chapter), made up the remaining 19% of agency support. The overall composition of agency revenues is summarized in Table 6.

REVENUE TRENDS

Boston providers reported that total agency revenues — including funding from state contracts and all other sources — rose by 6.7% in 1990 after a 12.9% increase the year before. Although aggregate 1990 growth was greater than the 5% increase in prices, a majority of agency budgets did not keep pace with rising costs; 56% reported declines in total real revenues in fiscal 1990. The basic trends in agency revenues by major source are discussed below and are summarized in Table 6.

Table 6

Summary of Agency Revenues

Boston-Based Private Provider Agencies

Revenue Source	Percent of Agencies Reporting Any Revenue from Source (Fiscal 1989)	Share of All Agency Budgets (Fiscal 1990)	Change In Revenues (Fiscal 1990)
State Contracts	90%	45%	2.3%
Medicaid/Medicare	23	15	13.0
City Sources	44	4	(13.5)
Federal Sources	30	6	2.7
United Way	35	4	2.9
Other Charities	80	7	6.8
Other (Implied)	NA	16	14.7
TOTAL REVENUES	**100**	**100**	**6.7**

State Contracts

For most Boston provider agencies, state contract funding in fiscal year 1990 did not keep pace with rising costs. Seventy-one percent reported declines in real dollar (inflation-adjusted) state contract funding in fiscal year 1990. In nominal terms, about one-third of private agencies each reported increases, declines, and no change in contracts.

Boston agencies reported a combined 2.3% nominal increase in state contract awards in fiscal 1990. This modest rise, amounting to $4.3 million on a $187 million base, does not reflect the experience of typical agencies, however. It is dominated by a large, $6 million rise in a single large agency. Together, the remaining providers experienced a $1.7 million, or 1%, *decline* in contract awards.

Reimbursements

Reimbursements for service are made after-the-fact based upon actual services delivered and their costs. This contrasts markedly with contract funding, in which service levels and prices are negotiated in advance of service delivery. For agencies receiving reimbursements, primarily those delivering health and mental health services, these revenues are a significant source of bottom-line stability and support.

Agencies reported that revenues from Medicaid and Medicare reimbursements rose by 13% in fiscal 1990[2], for example. But these revenues are available only for very specific purposes and only 23% of all agencies reported them as a source of support.

Agencies with any source of reimbursements — from Medicaid, Medicare, Blue Cross/Blue Shield, or other private insurers or third-party payors[3] — reported much better overall revenue performances in both 1989 and 1990 than agencies without these. Agencies with reimbursements experienced a reported 11.9% rise in total revenues for fiscal 1990 after a 17% increase in 1989. Both of these figures are much higher than the comparable estimates for all other agencies, 3% and 10.1%, respectively (see Table 7).

Table 7

Total Revenue Growth and Reimbursements

	FY89	FY90
Agencies with reimbursements	17.0%	11.9%
Other agencies	10.1	3.0
All agencies	12.9	6.7

Other Government Support

Revenues attributed to city and federal sources performed much more poorly than state contracts in 1990. City-source revenues (down 13.5%) and federal-source funding (up 2.7%) combined for an overall decline of 3.8%.[4]

Charity

Support from charitable sources did not surge in response to the fiscal crisis in 1990. Revenues from all charities rose by 5.4%. United Way funding, available to about one-third of the responding agencies, increased by a total of 2.9%. While United Way funding represents only about 4% of the combined budgets of human service providers, it is

an important source of support for agencies which receive it, comprising more than 10% of their budgets.

Contributions from charities other than the United Way expanded by 6.8% in 1990 to comprise 7% of agency budgets. In contrast to United Way funding, most agencies (80%) reported some level of charitable support. The most important source of charity is funding provided by the United Way followed by private corporations and foundations, contributions from individuals, and funding from federated fundraisers other than the United Way, such as Community Works. The distribution of charitable dollars is shown in Table 8.

Table 8

Charity

	Fiscal Year 1990 Distribution of Charitable Support
United Way	36%
Other Federated Campaigns	7
Private Corporations and Foundations	33
Personal Contributions	25

Fees

Fifty-one percent of all agencies (99/193) reported that they charged fees. These include most (80%) of the agencies which receive reimbursements (see above). Also frequently reporting fees as a revenue source were agencies providing day care and elder services. Agencies providing job training, homeless services, or services to those with special needs were unlikely to report using fees.

Like reimbursements, fees (and fee increases) help to insulate agencies and services from state funding changes. While the survey did not include detailed questions on fee increases, there is indirect evidence that fees usually have been raised in fiscal 1990. The 60 agencies surveyed which levied fees but did not report any reimbursements from Medicaid, Medicare, or private third-party payors reported an overall reduction in state contracts of 6.4% but an increase in total revenues of 1.2%. This implies that non-contract funding rose by 8.9% during the year. We suspect that increases in fees may be a significant component of this rise. As of yet, it is not possible to determine: (1) what the exact fee increases for 1990 were; or (2) whether these increases were unusually high.

Summary

Privately-provided human services were virtually level-funded by the Commonwealth in fiscal 1990. Service areas most affected by funding reductions included homeless services, elder services, and adult education and job training.

Boston's private providers reported a combined rise in state contract funding of 2.3%. The same agencies reported a 6.7% increase in revenues from all sources. This implies that revenues from all sources other than state contracts rose by 10.4%. Reimbursements from public or private third-party payors, such as Medicaid or Blue Cross/Blue Shield, and fees are apparent sources of growth in non-contract revenues. Agencies with reimbursements experienced a 14.6% increase in non-contract revenues and agencies with

fees (and not reimbursements), an 8.9% rise. Agencies with neither fees nor reimbursements, nearly half of the total, experienced only a 0.7% rise in non-contract revenues.

In sum, these analyses show that while nominal state support for privately-provided human services has not declined, private provider agencies in general have experienced slower rates of revenue growth in 1990 than in 1989, and the majority have experienced real revenue losses with regard to both state and total support.

IV Agency and Service Delivery Adjustments

What changes in agency operation and service delivery have occurred as a result of funding reductions?

A major unknown, and hence a question of great interest to this study, is how agencies behave in response to these changing revenue trends. In response to declining resources, private agencies may be forced to cut their own budgets, reduce staffing, find additional funding sources, alter methods of service delivery, or make other expense-reducing adjustments. Agencies may also finance operations through deficit spending and borrowings. This possibility, about which the community is rightly concerned, will be evaluated later in this research. Finally, agencies may reduce caseloads or service levels. (This category of changes is treated separately in the next chapter.)

In this section, evidence is offered which suggests that a number of these changes occurred among Boston's private agencies in 1990. Seventy-one percent reported making cuts in one or more areas of their budgets, 30% reported at least one layoff, and 42% reported some loss of staff due to attrition. Agencies also reported that several budget-stretching changes in program operation occurred in 1990 — shifts which raise questions concerning the quality and effectiveness of service delivery which need to be addressed.

The adjustment process is complex. Funding cuts can affect each program differently, depending upon the financial condition of the provider, the availability of other sources of support, program cost structures, and the external demand for services. Given these complications, this report focuses on documenting, rather than explaining, change. It does include initial explorations of some basic issues, however, such as the role that the fiscal crisis may have played in bringing these changes about.

Agency Budget Cuts

Seventy-one percent of all private provider agencies reported making cuts in one or more areas of their budgets in fiscal year 1990. More than one-third of the agencies reported making payroll reductions and over 40% made cuts in equipment, and in office supplies and related expenses.[1] Agencies were least likely (at 23%)to report reductions in (relatively fixed) occupancy costs (see Table 9). As expected, agencies reporting making cuts had much slower rates of revenue growth (3.7%) than those that did not (27%).

Table 9

Percent of Agencies Making Cuts by Budget Area

	Budget Area					Summary	
Service Area	Payroll	Maintenance & Repair	Equipment	Office & Telephone	Occupancy	Cut One or More Areas	No Cuts Reported
Mental Health	30%	42%	33%	30%	23%	69%	31%
Mental Retardation	45	68	64	55	36	82	18
Physically Disabled	27	40	40	60	20	67	33
Substance Abuse	33	33	33	25	18	78	22
Community Health	38	39	36	41	29	80	20
Elder Services	42	58	58	68	42	84	16
Day Care	38	57	60	56	38	79	21
Adult Education & Employment Training	43	44	51	51	20	86	14
Homeless Services	25	30	25	32	19	57	43
Services for Battered Women	33	17	17	17	33	50	50
Counseling	56	50	56	58	36	92	8
Other Youth Services	43	44	54	54	32	82	18
TOTAL	33	39	43	45	23	71	29

Agencies most likely to report making internal budget cuts offered services in the areas of counseling (33/36 agencies reporting cuts), job training (30/35), and elder services (16/19). Also likely to report reductions were agencies serving the mentally retarded (18/22) and youth (23/28).

Larger agencies were more likely to report making cuts in their budgets. The very largest agencies — those with budgets greater than $2.5 million in 1989 — reported budget cuts in at least one budget area 80% of the time (37/46) compared to 67% for all other agencies (89/132). With the exception of the smallest agencies, which reported cuts as often as average, the tendency to report cuts increased with size. This is not because larger agencies experienced greater funding cuts. No statistical relationship between agency size and changes in contracts or revenues was found. Instead, these results may reflect the fact that larger agencies are better able than smaller ones to make marginal budgetary changes.[2]

Staff Reductions

Staffing patterns in 1990 showed signs of early stress. While staff levels in our surveyed agencies declined only slightly, this compared with an increase in the previous year of 7.5%. Across all service areas, agencies fell behind 1989's rate of staff growth.

Total staffing among private agencies in Boston remained relatively constant between fiscal year 1989 and the time of the survey (February, 1990). As such, the system's total capacity to serve remained stable. Even so, declines did occur in many service areas and 30% of surveyed agencies reported a net loss of staff. In the twelve months prior to the survey, 30% of agencies experienced at least one layoff and 42% reported some staff loss due to attrition. Among public agencies, staffing cutbacks were more pronounced, as shown below.

The total full-time-equivalent (FTE) staffing for 179 agencies in the survey (with valid responses) was 7,850, for an average of 44 per agency. Most agencies are much smaller, however. Half have staffs of 20 or less. Based on the survey's overall response rate, the total private human services workforce in Boston is estimated at approximately 11,600. State-wide, it has been estimated that private human service providers employ at least 44,000.[3] The Boston figure represents one-quarter (26%) of this total.

The most severe staff losses occurred among agencies serving the mentally retarded and the mentally ill. Losses were also reported by agencies providing elder services, day care, battered women's services, and youth services. To the extent that staff levels are a proxy for ability to serve, these are the areas which may be experiencing real losses of capacity.

For the 30% of provider agencies (59/194) that reported at least one layoff in the twelve months preceding the survey, layoffs represented 2.8% (243 positions) of total current staffing. Agencies which lost the largest shares of staff to layoffs included those providing services to battered women (8.1%), elder services (6.8%), and job training (6.1%). Reports of staff loss due to attrition were more common, at 42% of all agencies (80/192). Reported attrition equaled 4.5% of current staffing (369 positions). The agencies reporting the highest rates of attrition include those delivering elder services (11.5% of current staff) and services to battered women (6.4%).

To provide some perspective, a comparison to levels of state employment in human services is in order. State human service agencies reported a 4.8% staffing reduction during the 19 months ending in January, 1990. This reduction, which amounts to 1,850 positions, occurred in spite of mandated increases in corrections (379 jobs or 8.7%) and state schools for the mentally retarded (111 jobs or 1%). Removing these two items, which were earlier identified as "non-discretionary," EOHS staffing falls by 9.7% over this period, with declines reported in virtually every catagory of service.

Table 10

Staffing Patterns in Human Service Agencies

	FTE Staff			Change FY88-89		Change FY89-Current		Number of
Agencies with programs in	FY88	FY89	Current	FTE	Percent	FTE	Percent	Responses
Mental Health	1,839	2,062	2,001	223	12.1%	(61)	(3.0%)	23
Mental Retardation	1,941	2,201	2,087	260	13.4	(114)	(5.2)	21
Physically Disabled	581	663	685	82	14.1	22	3.3	14
Substance Abuse	1,175	1,240	1,295	65	5.5	55	4.4	35
Community Health	1,971	2,009	2,011	38	4.4	2	0.1	30
Elder Services	771	800	788	29	3.8	(12)	(1.5)	13
Day Care	1,802	1,803	1,752	1	0.1	(51)	(2.8)	43
Adult Education & Employment Training	961	1,018	1,051	57	5.9	33	3.2	29
Homeless Services	1,234	1,270	1,276	36	2.9	6	0.5	26
Services for Battered Women	132	126	124	(6)	(4.5)	(2)	(1.6)	6
Counseling	1,755	1,847	1,875	92	5.2	28	1.5	34
Other Youth Services	1,607	1,693	1,674	86	5.4	(19)	(1.1)	26
TOTAL FOR AGENCIES	7,355	7,867	7,850	512	7.5	(17)	(0.2)	179

Table 11

Summary of Staffing Changes in the Executive Office of Human Services

EOHS Department	FTE staffing as of Jul-1-1988	FTE staffing as of Jan-30-1990	Change FTEs	Change Percent
Commission for the Blind	118	92	(26)	(21.9%)
Rehabilitation Commission	69	57	(12)	(18.0)
Commission for the Deaf	54	43	(10)	(18.8)
Office for Children	326	275	(52)	(15.9)
Veterans Affairs	54	43	(11)	(20.4)
Soldiers Homes	874	742	(132)	(15.1)
Youth Services	638	576	(61)	(9.6)
Corrections	4,349	4,729	379	8.7
Parole Board	214	210	(4)	(1.8)
Welfare	4,712	4,088	(624)	(13.2)
Public Health Hospitals	3,401	3,046	(355)	(10.4)
Other Public Health	850	698	(152)	(17.9)
Social Services	2,764	2,530	(234)	(8.5)
Mental Health Hospitals	4,592	4,488	(104)	(2.3)
Other Mental Health	4,213	3,800	(413)	(9.8)
Mental Retardation State Schools	10,160	10,271	111	1.1
Other Mental Retardation	961	870	(91)	(9.5)
Other EOHS	310	250	(60)	(19.4)
TOTAL	**38,658**	**36,808**	**(1,850)**	**(4.8)**
TOTAL excluding corrections and state schools	**24,149**	**21,809**	**(2,340)**	**(9.7)**

Finding New Money

Provider agencies have responded to reductions in state resources by seeking new or increased funding from other sources. But it is hard to find new money. Although there are several options to pursue, most are either inadequate or inaccessible. They include: (1) the replacement of lost state contracts with others; (2) an increase in funding from charitable sources; (3) an increase in federal funding; (4) increased fees; and (5) increases in reimbursements from Medicaid, Medicare, and other third-party payors.

Funding alternatives, even when they are available, may fail to prevent the negative effects of reduced resources on current services. Ideally, in order to mitigate those effects, new resources would have to be dedicated to the same purposes as was the lost funding, so that agency and program operations can continue unaffected by the initial funding change. But this is not generally the case. Most non-state funds, including private contributions, are often restricted, and new monies dedicated to one purpose cannot easily replace funding dedicated to another. Thus, new funding sources may do more to protect agencies than clients. In exchange for greater financial security, both the mission and clientele of agencies may have to change.

Testing these propositions will take time, however, since we anticipate a lag in agencies' abilities to generate new funds. The collection of data to investigate these revenue substitution possibilities will proceed in later phases of SPRG's work on this project. Below, we briefly discuss the revenue alternatives and their potential to replace lost resources.

Replacing State Contracts with State Contracts

State contract awards were very volatile in fiscal 1990, with many agencies reporting large increases and decreases despite level funding overall. These shifts cannot be explained by funding trends for individual services; rather, they suggest that agencies may gain, lose, or walk away from contracts at a very high rate. The transfer of contracts among agencies may be a standard feature of the single-year contract system[4] or partly the result of funding reductions and state policy changes associated with the fiscal crisis itself — it is too soon to know which. In either case, new contracts may change the mix of services offered and, with it, the population served by the agency. Again, replacement contracts may offer little opportunity to finance current services.

Charity

The fiscal crisis has placed enormous pressure on private funders to step in and fill state funding gaps. This is not possible in the first instance, because funding from all charitable sources accounts for only slightly more than 10% of all agency budgets, while government contracts and grants[5] are five times as large. Secondly, provider agencies reported that charitable support rose by only 5.4% in 1990, reflecting little more than an inflationary increase.

Despite reports in the media that private corporations and foundations are targeting more of their resources to human service providers, the amount of support they can give is limited and — due to the same economic forces which restrict state revenues — not growing rapidly. Still, agencies are pursuing charitable dollars. Two hundred seventy agencies approached the United Way of Mass Bay for fiscal 1990 funding, for example. Of this number, only eight completed the applications process and were accepted as new affiliates. Because the United Way's total allocations actually fell, two of these eight did not even receive first year funding. The six that were funded received only $159,000 among them.[6]

The adequacy of these resources aside, the role of private support in this environment of reduced resources will remain an important issue for the life of this study. In these early investigations, our analyses indicate that grants and contributions from foundations, corporations, and other private givers do not appear targeted to the agencies which were cut. Agencies receiving these grants were just about as likely to report increases in state contracts (39%) as declines (42%). In fact, a positive correlation between state and charitable funding was found.[7] That is, agencies which received above-average increases in state funding also tended to receive above-average increases in charitable giving. Agency revenues from the United Way were also unrelated to changes in agency state revenues.

Federal Dollars

Federal dollars are also unlikely to fill large gaps created by state cutbacks. Federal support was reported by only 30% of Boston providers, with 1990 growth of only 2.7%. Nationally, federal outlays for all social services rose by only 2.5% in 1990 and for all federal job training programs, 3.1%. In some areas, increases in federal resources are expected, however — most notably the War on Drugs initiative, which includes 12% increases in the 1991 budgets for both treatment and prevention services. Here too, as earlier, revenues from federal grants are made for categorical purposes and may not be appropriate for substitution.

Fees

About one-half of all private provider agencies receive fees paid by individual clients. Above, it was suggested that fees were probably increased in fiscal 1990. But fees are a feasible option only in service areas where clients are willing and able to pay. In some service areas, such as job training, homeless services, or special needs services, it is not reasonable to expect clients to provide much program support. Further, where fees are feasible, increases beyond the clients' ability to pay could lead to a significant reduction in caseloads and reduced total fee support. More important, they could limit clients' access to care.

Further research is planned on this topic, which will describe the fee increase experience of Boston providers and explore the issues of ability to pay and access to services.

Reimbursements

Only about one agency in five currently provides services for which reimbursements through Medicare, Medicaid, or private insurers are possible. These agencies may be able to increase support from these sources by placing more emphasis on those services. While this strategy will clearly help the agency financially, it provides little support for programs and services offered by the agency which are not reimbursable. In the long run, the pressure to provide more reimbursement-based and less contract-based services may result in a reduction in the menu of services available to the community.

Many observers interviewed suggested that community health centers in Boston have been an example of this phenomenon. Mostly founded about 20 years ago, the original mission of many of the centers included both medical (reimbursable) and social (contract) services. According to one observer, the pressures to maximize reimbursements has led to the increasing "medicalization" of community health centers in Boston, at the expense of social programs.

In general then, while alternative sources of revenue do exist, we suspect that securing new revenues may prove difficult and that, even where successful, agencies will be constrained in most cases from applying new funds to on-going programs and services. Future analysis will investigate these issues more definitively.

Changes in Service Delivery

In our telephone survey, we also sought to determine whether private agencies would look for ways to achieve budget savings through internal changes in operations and service delivery. In survey responses, summarized in Table 12, agencies reported a variety of budget-stretching changes in program operation in fiscal 1990. These included increased staff workloads, longer working hours, less frequent client contact, shorter overall treatment periods, and an increased reliance on group treatments. It is too early to say, however, whether these changes were deliberate adjustments initiated by the provider. Many factors, including regulatory requirements, policy changes, and changes in the external demand for services, may also affect service delivery. More study is planned to help describe and explain these trends. Regardless of their causes, however, these shifts raise questions which must be addressed about how the quality of available services might be changing.

Group Treatments

Twenty-six percent of all service areas[8] reported increased reliance on group treatments. This option is not meaningful for all service areas, however. Day care programs, for example, do not report this shift. Service areas most likely to report this change were mental health (52% or 13/25) and substance abuse (44% or 14/32). Also frequently reporting increased group activities were job training (34% or 11/32) and counseling (31% or 11/36).

Frequency of Client Contact

Twenty-one percent of all service areas reported that clients were being seen less frequently than they were one year earlier. One out of every three agencies providing counseling, elder services, services to battered women, and services to the disabled reported this change. Program areas typically requiring daily client contact were unlikely to report this change, including daycare (0% reporting), homeless shelter (13%), and mental retardation (15%). Similarly, agencies delivering health services because of their intermittent demand were also less likely (17%) to report this shift.

Treatment Periods

Twenty-two percent of service areas reported that overall treatment periods were shorter in 1990 than in the year before. Most likely to report this change were elder services (39% or 7/18) and mental health services (36% or 9/25). In addition, 31% (11/36) of all counseling programs reported shorter treatment periods. As with other operational changes reported above, this option was not uniformly available across all service areas. Agencies serving the mentally retarded and day care agencies did not report this change.

Staff Workload

Most service areas reported that staff caseload and effort (hours worked) had increased over the past year. Fully 61% (174/287) of all service areas reported an increase in the

Table 12

Changes in Service Delivery

	Agencies Reporting							
	Increased Reliance on Group Treatment		Reduced Frequency of Client Contact		Reduced Treatment Periods		Increased Staff Caseload	
Service Area	Percent	N	Percent	N	Percent	N	Percent	N
Mental Health	52%	25	24%	25	36%	25	69%	26
Mental Retardation	5	20	15	20	5	20	30	20
Physically Disabled	21	14	36	14	31	13	36	14
Substance Abuse	44	32	16	32	19	32	66	32
Community Health	21	34	17	35	14	35	63	35
Elder Services	17	18	33	18	39	18	61	18
Day Care	0	19	0	19	5	19	26	19
Adult Education & Employment Training	34	32	25	32	16	32	81	32
Homeless Services	17	24	13	24	21	24	46	24
Services for Battered Women	17	6	33	6	17	6	100	6
Counseling	31	36	33	36	31	36	72	36
Other Youth Services	24	25	12	24	28	25	68	25
TOTAL	**26**	**285**	**21**	**285**	**22**	**285**	**61**	**287**

N = number of agencies in service area

caseload per staff. Service areas which were very likely to report an increase were battered women's services (100%), job training (81%), and counseling (72%). Least likely were daycare (26%) and mental retardation services (30%), where minimum staff ratios are partially set by regulation.

Almost as many service areas, 50% (143/188), reported an increase in the number of hours worked by staff. Sectors most frequently reporting longer hours were battered women (67%), job training (66%), and youth services (64%).

Summary

The question of what adjustments agencies have made as a result of funding reduction is not immediately answerable. While our telephone survey clearly indicates that agencies are making changes in their budgets, staffing and service delivery, we are unable to determine the extent to which these changes are related to the budget crisis alone. While many of these shifts may be the result of deliberate agency resource-saving initiatives, they may also to some extent be results of policy changes or changes in the needs of the community.

With regard to findings of shifts in service delivery, for example, statistically significant correlations between changes in 1990 revenues and three concepts — staff caseloads, staff hours, and reliance on group treatment — were found. Somewhat surprisingly, however, these relationships were positive — that is, agencies with larger overall revenue increases were more likely to report the supposedly budget-stretching changes in service delivery. This finding suggests that forces other than budget constraints may be at work in generating some of the changes reported in service delivery.

Additionally, it is not possible to say whether the changes we are observing are good or bad. For a number of reasons, including agency capacity, intensity of client needs, and differences in service methods, agencies may be able to increase caseloads without disservice to clients. Moreover, increased use of group modes of treatment in counseling services, for example, does not necessarily imply deterioration in the quality of that service. Larger ESL classes may still effectively teach English. Taken together, however, these changes in modes of service do at least raise the issue as to whether or not, and if so how, the quality of care is being effected.

Since evaluations of each of the hundreds of program types under investigation here is not possible, the goal of this study is to identify and assess only the general trends that are affecting this human services system. As the research effort continues, these and other adjustments will be documented and analyzed in more detail to delineate these relationships more fully.

V The Impact on Clients and Caseloads

How have clients been affected by funding reductions and what is the effect on the community as a whole?

In fiscal year 1990, Boston's private human service providers served a smaller portion of those in need. The number of clients served was stable, but access to services became more limited. During 1990, the economy weakened and, by many measures, the need for services increased. With limited funds and rising demand, a larger share of caregivers' resources was targeted to those most in need. Thus, agencies reported that their clients were more difficult to serve in 1990 than they were in 1989. With access reduced, waiting lists increased across all service areas. These changes result in part from the confluence of rising needs and fixed resources, but they were also abetted by changes in public policies.

After discussing these client impact issues, this section introduces the more complex idea of community impacts — particularly raising the question of how the fiscal crisis has affected the city's minority community and specific neighborhoods. It concludes that funding decisions appear to be unrelated to the minority status of clients. The special roles played by agencies with predominantly minority caseloads may require special consideration, however, and future study will focus on the issue.

Clients Still Being Served

There was no widespread putting-out of clients in fiscal year 1990. Information collected in the survey of providers suggests that the number of clients served rose by between 2% and 5% in fiscal 1990 after a 5% to 10% increase the year before.[1]

Most Boston agencies were able to serve at least as many clients in 1990 as in 1989, but without the more rapid expansions of the earlier year. Only about one-fifth (22%) of all private providers reported serving fewer clients in fiscal 1990. In contrast, 41% reported increases and 37% said that their caseloads remained the same. This agency experience is very similar to that reported for fiscal 1989, except that agencies were much more likely to report large caseload increases (of 20% or more) in the earlier year, and less likely to report no change in caseloads. Table 13 summarizes these data.

Table 13

Changes in Clients Served, FY89 and FY90

	Percent of Agencies Reporting that Caseloads					
	Declined by more than 20%	Declined by less than 20%	No Change	Increased by less than 20%	Increased by more than 20%	
1990 Percent of Agencies	6%	16%	37%	26%	15%	100%
1989 Percent of Agencies	4%	14%	30%	26%	26%	100%

Among agencies that reported real reductions in 1990 revenues, three out of four (76%) were able to serve at least as many clients in 1990. Of these 90 agencies, 29% (26 agencies) reported serving more clients and 47% (42 agencies) reported serving as many. This "caseload preserving" behavior was not a unique 1990 phenomenon. In 1989 as well, 75% (48 out of 60) of all agencies experiencing a decline in real revenues reported serving as many or more clients.[2]

The association of declines in resources with increasing caseloads in many agencies suggests that either the amount of service delivered to each client has been reduced[3] or the cost of delivering services has been cut, or some combination of both.

Are agencies doing less for their clients? Some agencies did report that clients were seen less often in 1990 than in 1989 and that the total length of program involvement was shorter. But preliminary data suggests that system-wide service levels were roughly the same in 1990.[4] Further research is needed in this area.

Are agencies doing more with less? At the time of this report, this explanation seems the more likely. Many agencies reported longer staff hours and larger caseloads per staff, and state contracts did not include increases for cost-of-living raises for private agency workers. So real wages for agency personnel declined.

SPRG's analyses suggests that the relationship of caseloads to revenues is not straightforward. By itself, the one-year change in revenues is a poor predictor of caseload changes. The correlations between changes in revenues and changes in caseloads are small (.259 for 1989, .320 for 1990). While these statistics do indicate that caseloads and funds flows vary in the same direction (e.g., increases or decreases in one are associated with increases or decreases in the other), the relationship is not a strong one. Other influences are at work here and a more complete model is needed.

Finally, it can be argued that it takes more than one year for funding changes to affect caseloads and service levels. Faced with revenue reductions, agencies may protect clients for a limited time by exercising the other options available to them (and discussed in this report). Over time, however, as these options are exhausted, reductions in resources will affect clients and service levels directly. The issue then becomes not *whether* services and caseloads will be cut, but *when*.

Needs Rise

While the number of clients served by Boston's private providers remained stable in 1990, needs across the city rose. Evidence to that effect was found in the SPRG survey and in public sources and testimony.

CASELOADS MORE DIFFICULT

The profile of clients served by the network of private providers changed in fiscal 1990 towards a caseload which needed more intensive, more emergency, and longer term services. This conclusion is based on the responses of agency managers to a series of questions: "Compared to last year, has your caseload shifted towards clients needing: more or less intensive services, longer or shorter term services, more or fewer emergency services?"

Intensity of Need

A large majority (73%) of respondents across all service areas[5] reported that clients needed more intensive services.[6] Sectors most often reporting this result included job training, elder services, battered women's services, substance abuse treatment, counseling services and youth services. In each of these areas, more than four in five respondents reported this change. Respondents for services to the mentally retarded and the mentally ill were least likely to report a need for more intensive services.

What constitutes intensity of need varies by service area, however. In some cases, the problems of clients may themselves be more intense. Children may be more severely abused or the elderly more frail. In other cases, the immediacy of the problem may be greater. This is partly addressed in the question on emergency services, below. Finally, problems of clients may be more extensive. Homelessness or drug addiction may add complications to other problems for which clients are receiving services.

Longer-term Services

About half (47%) of all respondents reported that clients required longer-term services; only 11% reported that more short-term services were required. Job training providers were the most likely to cite the need for longer-term services, saying so 73% of the time. Sixty percent of shelter providers reported that the homeless needed longer shelter stays. Battered women's programs and services for the mentally retarded both reported, on balance, no change in this aspect of their client's needs.

Emergency Services

More than half (52%) of the responses across the twelve service areas reported that clients required more emergency services.[7] Every provider of battered women services reported this need, as did three out of four counseling service providers and over two out of every three providers of youth services. Mental retardation was the area least likely to report an increase in the need for emergency services, followed by health services (for which the term refers to medical emergencies) and mental health.

Table 14

Shifts in the Treatment Needs of Clients

	Percent Reporting More Intense Service Needs		Percent Reporting Longer- or Shorter-term Service Needs			Percent Reporting More Emergency Service Needs	
Service Area	More	N	Longer	Shorter	N	More	N
Mental Health	63%	17	48%	7%	15	37%	10
Mental Retardation	43	10	19	14	7	24	5
Physically Disabled	67	11	27	7	5	40	9
Substance Abuse	80	28	54	9	22	51	19
Community Health	67	24	39	14	19	36	15
Elder Services	84	16	42	11	10	58	12
Adult Education & Employment Training	85	28	73	9	27	NA	0
Homeless Services	68	18	60	4	16	60	16
Services for Battered Women	83	5	17	0	1	100	6
Counseling	81	30	53	14	24	75	27
Other Youth Services	80	20	40	20	15	68	18
TOTAL	**73**	**207**	**47**	**11**	**161**	**52**	**137**

N = number of agencies in service area.

Questions not asked of day care agencies.

MACROTRENDS AND COMMUNITY NEEDS

The fact that the needs of clients are greater mirrors broader social trends. Things are getting worse inside Boston agencies in part because they are getting worse outside Boston agencies. Without doomsaying, a strong case can be made that the needs of the community, figured both in terms of the number needing assistance and the virulence of their need, were substantially greater in fiscal 1990 than in the prior year.

Fiscal 1990 was not a good year in Massachusetts. Total employment in May, 1990, was 1.8% below its May, 1989, level. The state's jobless rate rose from less than 4% in the last quarter of fiscal 1989 to 6% at the close of 1990. Concurrent with this employment slowdown was a dramatic rise in the caseloads for AFDC and General Relief. AFDC caseloads, stable at around 85,000 families during the boom years of the 1980s, rose to 98,027 families by the end of fiscal 1990 — a 15% increase during the decade. Nearly half that 10-year increase (6,800 cases) occurred in 1990.[8]

The community health needs of Massachusetts residents continued to rise in 1990. There are an estimated 28,000 people in Massachusetts with AIDS[9] and the number of new infections is increasing by 1,760 people per year, or roughly 7%. Fewer than 60 housing units currently exist statewide for people with special needs because of AIDS. Five thousand fourteen are needed and demand will top 6,800 by 1994. Besides demanding additional resources in its own right, the spread of AIDS has complicated service delivery in other areas. Most notably, providers of substance abuse treatment and homeless shelter have been forced to address the needs of clients with AIDS.

Other pressing community health problems include rising infant mortality and rising teen pregnancy. The infant mortality rate in Boston was 14 per every thousand births in 1988. This rate represents a 5% increase over 1987 and an alarming reversal of the prior year's (1986) 14% decline. Among minorities, the rate was 21/1000 — 2.5 times the rate for Boston's white residents.[10] The most recent data in Massachusetts showed that the state-wide teen birth rate rose by 7.5% in 1988 to 34 births per thousand.[11]

The rising crisis among families and youth has been well documented.[12] Cases of severe abuse have risen steadily during the 1980s, rising by 16.6% in fiscal 1989 alone. More than 10,000 children state-wide are in foster care or group homes, and this figure is now growing by as much as 20% per year. The total number of DSS (Massachusetts Department of Social Services) reports and cases have also risen every year. In calendar 1989 alone, DSS responded to more than 70,000 reports.

In Boston, more than 1,800 kids drop out of school every year.[13] In 1989, 837 youth were committed to the custody of DYS, up 17% in one year.[14] Hotline calls to battered women's service groups almost doubled between 1985 and 1989, from 34,000 to 62,000 calls.[15]

There has been a great deal of discussion in the community about the role increased substance abuse, and especially crack use, may have on other social problems and on social service delivery systems. Substance abuse is a complicating factor in a variety of areas ranging from poverty and homelessness, to criminal behavior, to child health and abuse. In the state's penal system, for instance, estimates of the number of inmates with a drug or alcohol problem range as high as 40%.[16]

These larger recent developments compound an already significant level of need in the community. The most recent comprehensive report on poverty in Boston, a study commissioned by the Boston Foundation, *In the Midst of Plenty*[17], reported that one in every five Boston families lived in poverty in 1989. This statistic, while evincing a significant level of need, is actually an improvement over 1980 when the ratio was one in four. Even with the decline in poverty rates, one out of every three children in Boston are poor and for Hispanic children, the ratio is three out of four.

Waiting Lists Get Longer

In each of the trend areas reported above, increases in need exceed the 2% to 5% increases in caseload estimated from SPRG's survey. As such, documented needs are expanding rapidly during a period when capacity appears constrained. This combination in fiscal 1990 produced a significant increase in the number of persons waiting for services throughout the human services system. A smaller percentage of those in need of services received them.

Overall, 71% of responses across the service areas surveyed reported that waiting lists were longer in 1990. Of these, 47% said that lists were much longer. In contrast, only

Table 15

Changes in Waiting Lists, 1990 Compared to 1989

	Percent of agencies reporting that iwaiting lists were					
Service Area	Much Longer	Somewhat Longer	No Change	Somewhat Shorter	Much Shorter	Number of Agencies Responding
Mental Health	25%	44%	25%	0%	6%	16
Mental Retardation	25	25	50	0	0	4
Physically Disabled	67	0	17	17	0	6
Substance Abuse	71	8	13	4	4	24
Community Health	31	25	31	13	0	16
Elder Services	67	11	22	0	0	9
Day Care	39	39	11	11	0	18
Adult Education & Employment Training	52	19	24	0	5	21
Homeless Services	33	33	33	0	0	6
Services for Battered Women	67	33	0	0	0	3
Counseling	50	22	17	6	6	18
Other Youth Services	36	27	36	0	0	11
TOTAL FOR SERVICE AREAS	**47**	**24**	**22**	**5**	**3**	**152**

8% reported that lists were shorter, and 3% much shorter. (An additional 22% reported no change in lists.) Most likely to report longer waiting lists were providers of battered women's services (100%), substance abuse treatment (79%), elder services (78%), and day care (78%). These results are summarized in Table 15.

WAITING LISTS LONG THROUGHOUT THE SYSTEM

The average wait for substance abuse programs reported by surveyed agencies as 11.2 weeks is very long. Last October (1989), EOHS reported that the average wait ranged between six and eight weeks[18], and the Department of Public Health estimated that between 800 and 1,200 people were actively seeking residential services.[19] For those in

need of treatment for addiction, long waits pose a special risk. The moment of self-realization, when they call for help, "may only come once" and prospective clients "may never ask again."[20]

People can wait for job training, but the 21 weeks reported in Table 16 is also a long time. Jobs for Youth, which provides education and job training for at-risk youth, reported that it turns down three applicants for every one it accepts.[21]

Mental health waits averaged 14 weeks in 1990. In February, 1990, 500 patients were waiting for community housing, day treatment, and club houses to support community living.[22] Six hundred were ready for discharge from state hospitals, but were waiting for community residential services.[23] As of May, 1990, an estimated 9,251 residential beds were needed statewide, but only 2,870 exist.[24]

Community agencies serving the mentally retarded rarely keep waiting lists.[25] Nevertheless, estimates midway through fiscal 1990 suggested that more than 1,500 mentally retarded clients were waiting for residential services. EOHS estimated that this figure would nearly reach 2,000 by June.[26]

Table 16

Summary of Reported Waiting Lists

			Lists Reported in Weeks		Lists Reported in Clients	
Program Area	Number of Agencies	Percent Reporting Lists	Weeks	N	Clients	N
Mental Health	26	58%	14.5	10	25.2	5
Mental Retardation	21	29	74	2	260	4
Physically Disabled	15	40	7	4	16	2
Substance Abuse	35	80	11.2	21	172	7
Community Health	36	50	3.4	14	37	4
Elder Services	19	42	6.3	4	63.8	4
Day Care	49	43	31	8	120.5	13
Adult Education & Employment Training	33	64	20.8	9	73.3	12
Homeless Services	25	16	30.7	3	5	1
Services for Battered Women	6	33	5	2	-	0
Counseling	36	56	6.1	14	48.5	6
Other Youth Services	25	44	10.7	6	32.8	5

The longest waits reported in the survey were for day care services, which averaged 31 weeks. For those day care providers reporting lists in terms of clients[27] (rather than wait time), the number of children waiting for day care was greater than the number served in a year. In January 1990, the state reported that 7,000 families were waiting for basic day care services.[28]

One shelter for battered women reported that "beds are always filled within a few hours of an opening" and they therefore must turn away nine out of every ten requests for shelter. The Coalition for Battered Women had a somewhat lower, but no less dramatic, estimate that the shelters serve half of those who ask for help.[29]

Given the study's observations thus far, the issue of who is served by the human services system may be in flux. Longer waiting lists signify reduced access to care generally. However, SPRG's findings that clients served in 1990 had greater needs than those the year before implies that access may have become especially difficult for potential clients with less pressing needs.

This issue will be a continued focus of SPRG's research on caseload impacts. Reduced access for those with less severe needs can entail a shift away from early intervention and prevention efforts. Further research will clarify whether preventive services have, in fact, been disproportionately cut, and will query the consequences of cuts in these services for the rest of human services system. The following discussion illustrates how access can be effected by changes in policies and funding.

POLICY CHANGES RELATED TO ACCESS

In fiscal year 1990, and in the few years which preceeded it, policy changes in several state departments helped reduce access to services. The most important, and recent, of these changes affect social services, but changes in homeless policy have also occurred.

Major changes in the Department of Social Service's (DSS) purchase-of-service system were implemented in fiscal year 1990. DSS is the largest consumer of community-based services (i.e., those provided by private providers), purchasing a wide range of family services, including counseling, protective services for women and children, foster care and adoption services, and transitional living programs for battered women and young families — as well as contracted and voucher daycare. The most significant change at DSS was the introduction of the Partnership Agency Services, or PAS, model of service delivery. The PAS model represents a significant shift in the relationship of provider agencies to DSS. Under this system, private agencies provide total case management, including a comprehensive set of services, for clients assigned by DSS. Previously, agencies could contract with DSS to provide selected services from a larger menu.

The shift to the PAS system, combined with selected budget cuts, has contributed to a change in the types of clients served by DSS-funded agencies. One of the most visible manifestations of the DSS changes is a shift from open to closed referrals in provider caseloads. Closed referral clients are DSS cases assigned to provider agencies by the department. They are mostly children suffering from abuse and neglect who may need to be separated from their parents. Open referral clients, on the other hand, are not official DSS cases and their problems are more diverse. They include teen parents, runaway youth, and battered women, among others. Open referrals may also involve cases of abuse and neglect, but at an earlier stage of family crisis.

In fiscal 1990, about half of all the clients in counseling, mental health, and youth services programs were closed referrals. For most providers of these services, closed referrals were a more important source of clients in 1990 than in 1989, with 61% (31/51) reporting that closed referrals were on the rise while only 6% reporting declines. By contrast, providers with open referrals reported increases only 27% of the time (17/62) and decreases 23% of the time.

These statistics confirm a transition from a system which served clients with a variety of problems and at various stages of personal or family crisis towards one in which service is increasingly targeted towards clients who are already in the system and who represent the more severe abuse and neglect cases. Most affected by this trend are groups like teen parents and runaways. Open referral services to teen parents were cut by 35% in the October, 1989, round of EOHS budget cuts. This resulted in an immediate loss of services for 750 young families and may affect up to 3,000 annually.[30] In spite of its name, Place Runaway House, due to cuts in open referral funding, no longer serves runaways.[31]

Access to shelter has also been affected by policy changes. This year for the first time, families were required to undergo an assessment by DSS prior to getting into a shelter. The effect of this new rule is to deter families from seeking help. Ann Maley of the Massachusetts Shelter Providers Association explains how families react to the new rule:

> When families out on the street or those in intolerable, overcrowded situations hear that they have to go to DSS, they completely freak out. They don't understand.... All they know with DSS is your kids get taken away from you.[32]

CHANGING PRIORITIES

What is being described here is a sort of patient prioritization model where, because demand for service exceeds capacity, the human services system is shifting to serve the most needy first. This response may not be unique to the current crisis. A representative of community mental health agencies said, "What we do is limit services to [only] the sick people." This is not solely connected to recent funding changes — an evolving DMH strategy has focused more attention on chronically ill cases and "forced out people who enter the system not seriously mentally ill."[33]

The shift to more difficult cases and more needy clients has not posed financial difficulty for most agencies. As open referral funding and cases have declined, closed referral funding and cases have increased. The result, from the perspective of total agency resources, is neutral. Indeed, no significant relationship was found between revenue changes and the shift toward clients with more intensive needs.

The analyses do, however, raise the possibility that prospective clients needing less intensive services and care may be increasingly disadvantaged in their search for services, and that programs offering prevention or early intervention services may have been put at risk.

Toward an Assessment of Community Impacts

Throughout the past year, public concern has been raised that the state's fiscal strain might do inordinate harm to particular communities within Boston through cuts to agencies serving their residents. Of special concern here has been the impacts on Boston's minority communities, already recognized as most dependent on these ser-

vices. There are at least three facets to this concern which must be tested in this research: (1) whether a disproporionate share of all budget cuts fell upon minority agencies; (2) whether minority agencies are less able than most to absorb any cuts; and (3) whether there are special roles played by minority agencies in the community that need to be protected.

The first of the three concerns asks whether funding decisions in fiscal 1990 were biased. This is the simplest of the three to address. In SPRG's analyses, no general relationship was found between changes in state contract awards and the minority share of caseloads. Of the small number of minority-serving agencies, however, many did report being cut.

The analytic framework with which the second issue, that of vulnerability, can be addressed has not yet been developed. As a rule, however, minority-serving agencies were found to be smaller than other Boston providers.

Finally, the special roles played by many agencies with predominantly minority caseloads (e.g., caregiver, advocacy, social center, employer, and community organizer) may be threatened and therefore may deserve special protection. This issue introduces the concept of community-serving agencies into these analyses. To what extent do agencies serve individuals, and to what extent do they serve communities? This is a very complex idea, which future study will attempt to clarify.

WHO IS SERVED BY BOSTON'S PRIVATE PROVIDERS?

As a first step toward assessing community impacts, we explore who is being served by what parts of the system. Table 17 provides the data.

Minority Clients

As the Table shows, a majority (61%) of the clients of Boston's provider agencies are non-white. Based on agency responses, an estimated 39% of clients are white, 36% are African American, 16% are Hispanic, 6% are Asian, and 3% belong to other racial

Table 17

Ethnic and Racial Composition of Clients

	Average percent of caseload, by ethnic or racial group					
Service Areas	Hispanic	Asian	African American	White	Other	Number Responding
Mental Health	16%	5%	21%	56%	2%	24
Mental Retardation	6	7	23	64	1	21
Physically Disabled	19	4	25	49	2	14
Substance Abuse	15	2	28	52	4	34
Community Health	16	9	29	42	4	35
Elder Services	11	11	21	52	8	16
Day Care	18	6	43	30	3	46
Adult Education & Employment Training	27	13	29	26	7	33
Homeless Services	16	3	44	35	5	25
Services for Battered Women	16	6	33	13	33	4
Counseling	16	6	35	35	8	35
Other Youth Services	17	7	36	34	6	28
TOTAL FOR AGENCIES	**16**	**6**	**36**	**39**	**3**	**180**

Details may not add up to 100% due to rounding error.

groups. The minority percentage of clients is substantially higher than the minority share of the Boston population. In 1985, the BRA estimated that 38% of Boston's residents were non-white. The survey commissioned in 1989 by the Boston Foundation found that, among the non-elderly, 45% of Boston's population was non-white.

The data also shows that the different minority communities in Boston have different needs: more than one-quarter of the clients for adult education and jobs training agencies are Hispanic, for example, and Asians comprise 13% of the caseloads of these same agencies. Asians also apparently make use of elder services in disproportionate numbers. The African American community, on the other hand, is more heavily represented in daycare centers and is the single largest contributor to the ranks of the homeless. Whites in Boston, on the other hand, consume two-thirds of the system's mental retardation services and over half of all services provided in mental health, elder services and substance abuse. So a large part of the answer to which, if any, communities will suffer most, rests upon where the state decides to cut services.

SPRG's analysis to date shows no relationship between changes in 1990 revenue levels and the proportion of minorities in agency caseloads. Specifically, changes in state contract funding were unrelated to the proportion of African Americans or Hispanics among agency clients. Asians constituted a notable exception. Agencies with larger than average shares of Asian clients did less well than other agencies in the competition for additional state resources. Other patterns of funding for minority agencies were not statistically significant. The issues of minority agency vulnerability and special roles await future analyses.

Despite the lack of statistically significant patterns in the funding of minority agencies, there are strong reasons to pursue additional research in this area. The first reason is that the small number of agencies with predominantly minority caseloads were more likely than average to report reductions in state contracts. Of the 14 responding agencies with a predominantly African American caseload (75% or more), 43% reported nominal losses in state contracts in fiscal 1990. This compares to 34% for all agencies. Only four agencies with a predominantly Hispanic caseload were interviewed, but three of these reported state contract reductions.

These results led to the second reason why further consideration of minority agencies is needed. The various roles, attended to earlier, that these agencies play within their communities are not well understood. The failure of even a few key agencies may have a serious impact on particular communities. One executive in a minority agency warns that "Minority community agencies have to be seen differently from traditional community agencies."

Serving Neighborhoods

A little more than one-quarter (26%) of agency managers in SPRG's survey described the service area of their agency as "one or more of Boston's neighborhoods." In addition, 17% said that they served the city as a whole, 27% said Greater Boston, and 30% said that their agency service area was eastern Massachusetts or the state as a whole. It is likely that, because of the city's role as a center, Boston agencies have larger service areas than the state-wide average.

Agencies most likely to report serving neighborhood areas included those providing health services (35%), elder services (40%), day care (48%) and youth services (32%). Half of all agencies naming a neighborhood area said they served Roxbury or Mattapan, and more than half said they served some part of Dorchester.

Changes in state contract funding were also unrelated to agency's geographic service area. The share of neighborhood-serving agencies reporting nominal contract reductions (39%) was somewhat higher than the average for all agencies (34%) but this difference was not great enough to be statistically significant. The tendency to report cuts did not vary with the size of service areas. Agencies serving "Greater Boston" reported cuts a similar 38% of the time as those serving the city as a whole (31%).

Summary

The state fiscal crisis, if protracted, will ultimately affect levels of clients served. Our analyses to date indicate these impacts have been delayed. In spite of level funding, most agencies reported serving as many or more clients in 1990 then they did the year before. Boston caseloads were up between 2% and 5%, but the needs of the caseload are changing.

At the same time that services may have been preserved for most current clients, there is evidence that entry into the system is getting more difficult, particularly for prospective clients with lesser needs. Service needs in Boston were rising faster than service capacity, causing waiting lists to lengthen to levels prompting concern. And policy changes at the state have begun to shift the service priorities of Boston agencies toward prospective clients with greater needs. Most agencies reported that 1990 clients were more difficult to serve and needed more intensive treatments and more long-term and emergency care. The shifts may imply some deterioration in the availability in preventive and low intensity services.

VI The System of Care

How do the impacts of funding reductions in individual agencies affect the entire system of care?

So far, the impact of the Massachusetts fiscal crisis on human services has been discussed in terms of how agencies and services have changed and how clients and the community have been affected. The final perspective taken in this report considers the effect on the entire human service delivery system.

The network of private provider agencies together with state human service departments constitute the system of care that responds to the multiple and evolving needs of Massachusetts citizens and Boston residents. But the myriad of programs and services supported by the state differ in their applicability and relevance across cases. Certain services because of a pervasive need and/or their primacy among needs may be key to the entire system. These "core services" will be identified in SPRG's research and will be considered an "infrastructure" of human services — meaning the basic set of services necessary for the human service system to function effectively. The connections between these core services and others in the system are very important to understanding how the fiscal crisis is affecting individual services and programs as well as the system as a whole.

The term system implies a network of agencies and programs working together to identify, assess, refer, and to treat and care for clients. In this analysis, the network of providers is found to behave more like a loose confederation than a true, integrated system. Still, various important connections do exist. Providers and observers of the human services system in Boston report that these connections have been strained by the budget crisis in fiscal 1990. In exploring the system-wide effects, SPRG will identify these connections and examine how changes in funding have affected them. This report begins the effort by discussing some of these basic connections to establish a starting place from which impacts can be assessed.

Assessing the System

The connections in this system are defined primarily by the movement of clients. The flow of clients through the human service system was established with a series of questions in which providers estimated the percentages of clients referred from and to various services and destinations. In addition, providers named public and private agencies with which they had referral relationships. These data do not reveal where inter-program connections and supports are deficient or how the fiscal crisis may be affecting the system of care. Rather, they provide a baseline from which future research can proceed in response to both issues.

The survey responses indicated that these connections may be very weak. Forty-two percent of all in-coming clients across all service areas were self-referred or walk-ins, and only 13% were referred by some other private organization. At the other end, only 28% of all out-going clients were reportedly referred to any other agency, public or private, and only 17% were referred out to another community-based (private provider) organization.

An empirical standard with which to judge this result is not available because the number of referrals which were actually needed is not known. Certainly, for some service areas referral rates should be low. Children in day care centers should not need referrals very often, for example. Still, given the earlier discussion of the needs in Boston and in Massachusetts, one would assume that more than 28% of all the system's out-going caseload would need referrals to a subsequent service.

There are several possible explanations of low rates of out-referral. One study concluded that providers do not risk making referrals to agencies with which they are not very familiar because ineffective referrals might damage their own relationships with clients.[1] Some have also mentioned that the rise in violence in Boston's neighborhoods has caused a reluctance to refer, and that, for youth in particular, the geographic distance of referral destinations has been narrowed because youth will not cross certain gang turf lines. A simpler explanation is that the needed programs are not available (or perceived as not available). As one agency executive admits, speaking about the low percentage of referrals made for youth programs: "I send them home, there are no services."

These results — that no referrals are made for four out of ten incoming clients and almost three-quarters of all outgoing clients — suggests that system of care may not be functioning as a truly interconnected system. Still, the following discussion will set the stage for future research on the connections that do exist.

Table 18

Referrals Received

	Percent of current clients who were referred by					
Service Area	Self-referred	Courts or Probation	Schools	Government Agency	Private Agency	Number of Responses
Mental Health	20%	10%	6%	40%	17%	25
Mental Retardation	9	6	6	73	6	20
Physically Disabled	31	4	30	29	5	14
Substance Abuse	38	15	4	15	19	34
Community Health	61	0	4	10	14	30
Elder Services	50	0	0	16	22	17
Day Care	56	1	5	23	15	45
Adult Education & Employment Training	51	3	5	24	12	30
Homeless Services	47	2	0	38	11	24
Services for Battered Women	44	4	1	34	17	5
Counseling	43	6	15	29	6	35
Other Youth Services	31	16	8	35	10	24
TOTAL FOR SERVICE AREAS	**42**	**6**	**7**	**29**	**13**	**303**

Data may not add up to 100% because of rounding or unspecified referral services.

Private agency referrals to daycare include 10.3% from voucher management agencies.

Table 19

Referrals Given

Program Area	Percent of clients who were referred to: Government Agencies	Private Agencies/Community Organizations	Not Referred	Number of Responses
Mental Health	13%	16%	72%	23
Mental Retardation	7	13	80	18
Physically Disabled	12	22	66	13
Substance Abuse	11	27	62	35
Community Health	9	18	74	29
Elder Services	4	15	81	15
Day Care	6	7	88	46
Adult Education & Employment Training	5	16	79	30
Homeless Services	29	26	46	23
Services for Battered Women	25	36	39	5
Counseling	10	17	73	35
Other Youth Services	12	15	73	23
TOTAL FOR PROGRAMS	**10**	**17**	**72**	**295**

Detail may not add up to 100% because of rounding or unspecified referral destinations.

Infrastructure and Service Connections

What connections exist among providers and how are they changing? There are three types of interdependencies among programs, labeled here infrastructural, intra-service, and inter-service.

A HUMAN SERVICES INFRASTRUCTURE

Infrastructural services such as housing and day care[2] support the operation of the human service system. They are services upon which others can be built and without which others may not be practical or effective. In fact, because of their primacy, infrastructural services and their funding levels may ultimately define the limits of the system's capacity and effectiveness.

Housing

The fiscal crisis has caused a retreat in the state's public response to the even longer-running crisis in the availability of affordable housing. Efforts derailed by funding changes included the Commonwealth's housing production programs, not discussed elsewhere in this report, and rental subsidy programs such as the Chapter 707 rental certificate program.

The number of new 707 certificates, 2,000 in both fiscal 1988 and 1989, fell off to 800 in 1990. In 1991, no new certificates are authorized and the number of families aided by this program is expected to fall, due to turnover, from between 15,000 and 16,000 in fiscal 1990 to 13,000 by the end of 1991.[3]

Many advocates have argued that the lack of housing is a major impediment to the effectiveness of other services. The withdrawal of this support will further exacerbate this problem. Advocates for substance abuse treatment have noted that the lack of housing tends to extend stays in in-patient and residential settings, backing up the entire system.[4] Similarly, battered women's agencies reported that the average stay in shelter was getting longer because of a lack of housing.[5]

Day Care

The availability of day care was also limited by level funding in fiscal year 1990 (as total state day care funding fell by 0.3%). This situation is expected to worsen with further cuts during 1991. EOHS estimated that a total of 2300 slots would be lost in 1990 and 1991.[6]

The full force of these cuts will not be visible among the day care centers in the SPRG survey because of the different funding trends for the state's two day care funding programs — contracts and vouchers. Spending for vouchers fell by 3.4% during the year while contracts rose by 1.1%. The centers in the survey, however, are much more reliant on contracts. While voucher funding represents more that one-third of the entire state day care effort, it funded only 19% of the slots among the day care centers included in the survey. The majority (57%) of center-based slots were funded through contracts.

Day care provides support for families so that parents can work or participate in other activities, such as training or counseling. In the survey, respondents reported that one-quarter of all center-based day care programs were supportive of some other service. Most often, day care is mentioned in association with the ET Choices program, which offers employment and training services to welfare recipients. Vouchers form an important component of a recent ET graduate's overall compensation package. Without this support, many ET graduates may find themselves unable to work and may be forced back onto assistance programs.

INTRA-SERVICE INTEGRATION

The term intra-service integration refers to relationships among the various programs and services within each of the twelve service areas of the study. These treatments must be *vertically integrated* to provide care to clients who have varying degrees of need and assign them to programs and providers offering the appropriate levels of care.

Well integrated intra-service connections will also be better able to support clients needing sequential exposures through a series of programs and services. For example, treatment for substance abuse generally follows a clearly defined pattern, beginning with detoxification, progressing to residential or outpatient treatment, and ending with some sort of on-going community support through groups like Alcoholics or Narcotics Anonymous. If one link in this treatment chain is weakened, the entire sequence of care can be jeopardized and/or made less effective. Survey respondents delivering substance abuse services reported that, because of long waiting lists for treatment, "detoxes are holding people longer than they need to...so that they don't have to turn them back out onto the street."[7]

In some areas, these connections are historically deficient. Mental health advocates claim that "the continuum of care has yet to be realized."[8] In other areas, there is a sense that these connections, once well developed, have deteriorated. One agency executive in employment and training complains, "We used to have a formal network. There was flexibility to tailor services to individual needs. For example, in education.... now, the network is weak and the client is not getting prepared to the level necessary for job referral."

INTER-SERVICE INTEGRATION

Across service areas, referral connections are necessary to meet the multiple needs of individual clients. This *horizontal integration* of services is more difficult to achieve and sustain and hence may be more fragile. Nevertheless, increasingly, human service practitioners and scholars have recognized the need to increase the horizontal integration within human services and improve these inter-service connections. Most recently, the argument that the different parts of the human services system serve the same clients was made by Harold Hodgkinson in *The Same Client*.[9] As above, to the extent that some of the clients needs go unmet, successful treatment through other services areas is made more difficult or impossible.

The most basic of these needs, discussed above as infrastructural services, are housing and day care. (Income maintenance is clearly another basic need but one that lies outside the focus of the study.) But there are other services that, while perhaps not basic, may take precedence in certain treatment strategies. For instance, services for substance abuse, health problems, or mental illness may have to be provided before a client can receive effective job training. As an example, 40% of state penal commitments are self-reported drug users.[10]

On the other hand, horizontal integration has also grown because of new social phenomena which have forced providers to forge new links. Substance abuse treatment agencies have had to deal with a dramatic rise in the number of HIV-infected patients. Homeless shelters also report this new problem. Shelters have to deal with mental illness as well. It has been reported that 40% of the homeless are mentally ill.[11]

SUMMARY

The impact of the state fiscal crisis on specific programs or private agencies should not be viewed in isolation. The network of providers, together with state human service departments, constitute a system of care which responds to the human service needs of individual clients and whole communities. To the extent that one part of this system is impaired, other parts will be affected as well.

Preliminary findings from the survey suggest that the system of care in Boston is not well integrated. Only a small percentage of the clients of private provider agencies were referred to them from any source and an even smaller share were referred out to another program or service.

Many important connections do exist within the system, however. Infrastructural services, initially defined to include housing and day care services, form the core of the human service system. In addition, a variety of programs and services are integrated both within and across service areas to meet varying and multifaceted client needs.

The connections upon which the system of care rests may have been weakened in 1990. In particular, decreasing access to housing and day care services may have repercussions throughout the network. Further research will focus on improving our understanding of the system of care and how it is affected by the state fiscal crisis and its impacts.

PART THREE:
CONCLUSIONS AND NEXT STEPS

VII Conclusions and Next Steps

The Social Policy Research Group began this study in response to growing concern about how the Massachusetts fiscal crisis would affect the state's human services delivery system. Many, in fact, feared and predicted permanent damage would be done. With this concern came a rising frustration that we, as a Commonwealth, did not know how to assess the risks posed to human services, or what those risks implied for people and communities. Even more troubling was the concern that we lacked a framework within which to describe the system of care that might be at risk.

This study begins an effort to explain how state-level budget decisions affect specific human services, the network of providers which deliver them, and, most important, the clients and communities who receive them. It also begins to define what human services are, how the system which delivers human services is organized, and how it functions.

Stressing the System

This report provides a summary of initial findings from the first phase of SPRG's research. As such, it reports on the responses of 198 executives of Boston private human services agencies and reflects discussion with dozens of city and state officials and human services advocates. We consider these findings preliminary in the sense that they are our first observations on how the human services system is behaving in this troubled fiscal environment. These understandings will both broaden and deepen as the project proceeds through its second year and as additional data collection and analyses proceed.

At this stage, however, those observations show that the human services delivery system was not, as some had feared, dismantled in fiscal year 1990. Signs of stress were evident, however, as private providers tried to cope with the effects of level state funding. For the large majority of agencies, level funding meant less real revenues overall. Still, most served as many or more clients in 1990 as they did the year before.

Although caseload levels were held relatively constant, other aspects of the system did change as agencies adjusted to declining revenues. Program resources were stretched — staff worked longer hours and had larger client loads, clients had less contact with programs. These shifts raise issues, far too numerous to address in this study, as to whether fiscal crisis may be affecting the quality of service delivery.

Clients changed, too, toward a population that had more severe needs and was harder to serve. With the needs of the community rising and service capacity constrained, waiting lists for services rose across all service areas. Agencies served those most in need first, making access more difficult for those with less severe needs. The long-term costs, in terms of the lesser emphasis on preventive and early intervention programs that these shifts imply, is unknown.

What these trends mean for the minority and neighborhood communities of Boston is not clear at this time. Evidence on contract awards provided by agencies did not reveal any bias in the allocation of state funds, but there may be other impacts associated with

declines which may be important to understand. Minority agencies may be more vulnerable than average, and they may play unique roles in the community. These considerations must be addressed by further research.

The network of Boston private providers must be well integrated both vertically and horizontally to constitute a system of care. At this stage in the study, we conclude that the network of private providers behaves more like a loose confederation than a truly integrated system. Only a small percentage of clients were referred from one agency to another. Still, important connections do exist and respondents to our survey suggest that these connections are being severely strained. Changes in resource levels in one area are reportedly having repercussions elsewhere. A longer-term objective of our research will be to determine the extent to which the infrastructure of human services — a set of core services initially defined as day care and housing which support the rest of the system — is being affected, and the implications of those effects for the system's capacity to respond to the needs of Boston residents.

Unanswered Questions and Next Steps

While our initial telephone survey and our many discussions yielded many insights as to how agency executives, policy makers, and others perceived the crisis affecting human services, many questions remain unanswered. Throughout the preceding pages some of them were suggested as subjects for future research. They are listed below in the context of the five questions that guide our effort.

FUNDING

- How do 1991 funding patterns compare with those observed in 1990?
- How have agency goals, directions and clients changed as a result of declining resources in various service sectors?

AGENCY ADJUSTMENTS

- What is the relationship between agency adjustments and changes in revenues? To what extent do agency adjustments result directly from the budget crisis as opposed to other influences?
- What can we infer about how the quality of services is being affected by changes in agency operations and service delivery?
- How successful are agencies in finding new revenues, and to what extent can those new revenues be substituted for losses in state support?

CLIENTS AND CASELOADS

- What happens to clients refused entry into these discretionary programs? Do they seek services elsewhere and what are the implications for growth in entitlement programs?

- Do resource reductions caused by the fiscal crisis pose particular problems for minority communities or particular neighborhoods within Boston?

THE SYSTEM

- How are core services affected by the fiscal crisis, and in what ways do they influence the system's capacity to respond to community needs? Besides housing and day care, are there additional services that are core to this system?

- Are there particular services, while not basic, that should take precedence in treatment strategies and what are the implications for human services budgeting strategies?

Over the next year, the study will produce two more reports. In addition to addressing the questions raised above, each report will provide an update, based upon 1991 budget levels, on the five questions guiding this effort. The next report, due out this spring, will also present a major focus on operations and service delivery in 1991. Our final report, which will provide our summary assessment of budget crisis impacts, will also present the findings from a state-wide survey and our assessment of whether our Boston observations are useful to state legislators as they consider future budget policy.

The Social Policy Research Group owes a great debt to many whose cooperation, assistance, and support were vital to the initial stages of this project.

NOTES

I: INTRODUCTION

1 Governor Michael Dukakis, Veto Message to the Legislature, August 1, 1990 (for fiscal year 1991 general appropriations act).

2 Ferdinand Colloredo-Mansfeld, chairman of the Vault, reported in *The Boston Globe*, Michael Rezendes reporting, February 1990.

3 *Purchase of Service Reform: Final Report*, Commonwealth of Massachusetts, Executive Office for Administration and Finance, Peter Nessen, Assistant Secretary, Office of Purchased Services, January 31, 1990.

II: THE FOUNDATIONS FOR STUDY

1 This figure, along with other budget numbers, represents administration estimates as of April 1990. Because of the late passage of the budget for 1991, it was not possible to include a revised, end-of-year figure for 1990 in this report.

2 Assistance programs include Medicaid, AFDC, General Relief, WIC, SSI, housing subsidies, and veteran's benefits.

3 The two terms, community-based and privately-provided, are often used synonymously. There are exceptions, however. DYS, for example, runs state-provided, but community-based, programs.

III: RESOURCES FOR PRIVATELY-PROVIDED HUMAN SERVICES

1 Besides being conventional wisdom, previous survey research (see Grossman et al, *The New York Nonprofit Sector in a Time of Government Retrenchment*, The Urban Institute Press, 1986) also has shown that older agencies are less dependent on government support, at least as recently as 1982.

2 It is likely that this figure underestimates actual growth because most agencies reported that their Medicaid revenues did not change in 1990. Agency managers may have found it difficult to estimate current-year Medicaid charges, which are established after-the-fact. This problem is much less evident among revenue sources like state contracts or grants, which are awarded prior to service delivery. In these cases, executives usually had specific estimates of current-year support.

3 Estimates of revenues from reimbursement sources other than Medicaid and Medicare were not obtained. Agencies did report whether they received any funding from these sources, however.

4 Because these figures are self-reported by agency managers and not drawn from agency financial records, there is some confusion concerning the ultimate source of funding. Monies associated with the federal Job Training and Partnership Act program, for example, could be reported as city funding because awards are made through the Mayor's Office of Jobs and Community Services.

IV: AGENCY AND SERVICE DELIVERY ADJUSTMENTS

1 Agencies were asked whether they had mad budget cuts in each of these areas: employee compensation, maintenance and repair, equipment, office supplies, postage and telephone, and occupancy. In addition to these, 53 agencies reported making cuts in some "other" area(s). Based on marginal comments made during interviews, at least 11 of these others are payroll related (including layoffs and wage freezes). If added to the first category, these would raise the share of agencies reporting cuts in payroll costs to 38%.

2 For example, a 1% cut in an agency with 100 FTEs on staff translates into one staff person. At a 20 person agency, the same 1% cut will not justify a 5% staff reduction.

3 Nessen, Peter, "The Business of Human Services", *The Provider*, Massachusetts Council of Human Service Providers, Vol 11, No. 6, June, 1990.

4 Traditionally state contracts were awarded annually. Besides being seen as overly bureaucratic, the one-year cycle contributed to provider instability by placing them in a start-up position each year; purchase-of-service reform is replacing it with a five-year contract cycle.

5 State, city, or federally funded.

6 Source: United Way of Massachusetts Bay

7 A correlation of .246 was found for 109 valid cases which reported both 1989 and 1990 contracts and charitable revenues.

8 Agencies were asked these questions for each of their service areas.

V: THE IMPACT ON CLIENTS AND CASELOADS

1 These estimates are imprecise because agencies do not employ a standard definition of "clients served."

2 It should also be noted that the opposite result was relatively unlikely: In 1990, only 19% (17/91) of the agencies experiencing revenue increases served fewer clients. In 1989, the rate was lower, 14% (16/115).

3 Caseloads are only half of the service equation. Actual service levels depend on the amount of service delivered to each client as well as on the number served.

4 In addition to information on the numbers of agency clients, data was also collected on the levels of service provided by each service area within agencies. Agencies offered a variety of measures of service delivery, including client or patient visits, hours of counseling, nights of shelter, days of residential service, and client slots filled. Given this diversity, it is not yet possible to add-up service levels, and only changes reported across time are presented here. Changes in these data closely match those for clients served with 23% of all agencies reporting reductions in 1990, 38% reporting no change and 39% an increase. Again, these changes are very similar to those reported for fiscal 1989 except that in the earlier year agencies were somewhat more likely to report a large increase.

5 Agencies answered these questions separately for each of their service areas.

6 Daycare services were excluded from this set of questions because the questions were judged not to be meaningful for these programs. References to total rates reflect this exclusion.

7 This question also excluded job training.

8 Source: Massachusetts Department of Public Welfare.

9 "AIDS report warns of housing crisis", *The Boston Globe*, 8/15/90, pp 1, 12.

10 *Advance Natality and Infant Mortality Data for Boston and Its Neighborhoods*, Boston Department of Health and Hospitals, 1988.

11 *Massachusetts Childwatch '90*, Volume 4, Massachusetts Office for Children, February, 1990.

12 See, for example, *Massachusetts Childwatch '90*, Volume 4, Massachusetts Office for Children, February, 1990. The statistics in this paragraph are drawn from it.

13 Source: Boston Public Schools.

14 *Massachusetts Childwatch '90*, Volume 4, Massachusetts Office for Children, February, 1990.

15 Source: Massachusetts Coalition of Battered Women Service Groups.

16 *Indicators of Substance Abuse in Massachusetts*, Division of Substance Abuse Services, Massachusetts Department of Public Health, Health and Addictions Research, Inc., p. 2.

17 *In the Midst of Plenty*, Boston Foundation, Persistent Poverty Project, December, 1989.

18 Source: The Executive Office of Human Services, *Additional Human Services Cuts: October 1989*. The estimate refers to residential and methadone treatments. The wait for detoxification was shorter (2-3 weeks).

19 Interview with Ann Tafe, Alcoholism and Drug Abuse Association, 1/26/90.

20 Interview with Ann Tafe, Alcoholism and Drug Abuse Association, 1/26/90.

21 "Jobs for Youth Puts School on Track", *The Boston Globe*, 1/29/90, p. 1,17.

22 Source: Alliance for the Mentally Ill of Massachusetts.

23 The Executive Office of Human Services, *Budget and Personnel Cuts: The Impact on Human Services*, January, 1990.

24 Source: Alliance for the Mentally Ill of Massachusetts.

25 The state Department of Mental Retardation, which refers most of the clients to community-based MR agencies, keeps these lists.

26 The Executive Office of Human Services, *Budget and Personnel Cuts: The Impact on Human Services*, January, 1990.

27 Agencies reported waiting lists either in terms of the length, in weeks, of the expected wait or in terms of the total number of clients on the list.

28 The Executive Office of Human Services, *Budget and Personnel Cuts: The Impact on Human Services*, January, 1990.

29 Interview with Joan Stiles, Massachusetts Coalition of Battered Women Service Groups, 2/15/90.

30 *Fact Sheet*, Alliance for Young Families, January 1990.

31 "Ferret out problems, forget about cures", *Boston Phoenix*, 4/6/90.

32 Interview with Ann Maley, Massachusetts Shelter Providers Association, 2/6/90.

33 Interview with Elizabeth Funk, Mental Health Corporations of Massachusetts, 1/1/90.

VI: THE SYSTEM OF CARE

1 de la Vergne, Marc Gordon, *Jobs for Youth: Improving Outreach to Boston's Hard-to-Reach* High School Drop-outs, Policy Analysis Exercise, Kennedy School of Government, Cambridge, 1988. p. 24

2 This list, obviously incomplete, reflects historical and cultural circumstances. In most other nations, for example, it would include health care. And daycare has emerged only in the last generation as a basic need which is sometimes publicly met.

3 Source: Massachusetts Coalition for the Homeless.

4 Interview with Ann Tafe, Alcohol and Drug Abuse Association, 1/26/90.

5 Interview with Joan Stiles, Massachusetts Coalition of Battered Women Service Groups, 2/15/90.

6 The Executive Office of Human Services, *Budget and Personnel Cuts: The Impact on Human Services, January*, 1990.

7 Interview with Ann Tafe, Alcohol and Drug Abuse Association, 1/26/90.

8 Interview with Elizabeth Funk, Mental Health Corporations of Massachusetts, 1/8/90.

9 Hodgkinson Harold, *The Same Client: The Demographics of Education and Service Delivery Systems*, 1989, Institute for Educational Leadership, Washington, D.C.

10 *Indicators of Substance Abuse in Massachusetts*, Division of Substance Abuse Services, Massachusetts Department of Public Health, Health and Addictions Research, Inc., p. 2.

11 Source: Alliance for the Mentally Ill.

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